



ZdravReform/ЗдравРеформ

**Option Period Final Report
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Prepared by:

Sheila O'Dougherty, Cheryl Wickham, Grace Hafner, David Miller,
Cari Ann Van Develde, Mark McEuen, Mary Murphy

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Introduction

The USAID-funded ZdravReform Program has been providing technical assistance to the governments in Central Asia since 1994 to comprehensively reform and restructure the health service delivery and financing systems at both national and local levels. Key program strategies have included developing a regional health reform model, collaborating closely with World Bank health sector projects and other donors, and working intensively in selected demonstration sites within each country to reform elements of the health sector within that geographic area and also facilitate extension or roll-out of the model to either the national level or other regions within the country. In June 1998, the ZdravReform Program was extended for a two-year option period in Central Asia to continue this important work.

The following report serves as the final project summary of ZdravReform activities in Kazakhstan, Kyrgyzstan, and Uzbekistan during the two-year contract option period from June 1998 through June 2000. The three sections of the report provide a summary of accomplishments, results, and lessons learned during implementation of the ZdravReform health model in Kazakhstan, Kyrgyzstan, and Uzbekistan. A short description of the regional health reform model developed by the ZdravReform Program in close collaboration with local governments is attached as Annex A. Annex B provides a financial summary for the project from January to June 2000.

I. Introduction

Kazakhstan has the most rapidly changing and decentralized policy environment in Central Asia, which has presented both opportunities and challenges for implementing and sustaining health sector development activities. Over the past five years, Kazakhstan has experienced radical changes in government structure, including moving the capital, merging oblasts, merging ministries, and decentralizing authority from the national to the regional level. In the health sector, a complete national health insurance system was established, dismantled, and is again being considered as a health financing policy option. The ZdravReform Program worked closely with national and local leadership over the past five years to adapt the Kazakhstan country program to the particular needs of this dynamic environment. The approach to implementing the health reform model evolved to be flexible enough to pursue rapidly changing targets of opportunity, build fundamental capacity that is less affected by changes in leadership, and strike the appropriate balance between regional and national level activities.

This flexible approach to program implementation allowed the ZdravReform Program to achieve results in all four of the main program areas, the impact of which can broadly be summarized as: (1) developing, testing and implementing working models of comprehensive, PHC-centered health system development in two demonstration sites; (2) rolling out the demonstrations to two oblasts, one of which is in collaboration with the World Bank-financed Health Sector Project; and (3) developing innovative and replicable strategies to adapt the implementation of the health reform model in the context of rapidly changing leadership, priorities, and policies.

II. Policy Environment

Kazakhstan has a long history of experimentation and innovation in policy, both within the health sector and beyond. While still part of the Soviet Union, Kazakhstan initiated one of the original health reform sites in a region of Zhezkazgan during the New Economic Mechanisms (NEM) beginning in 1989. Kazakhstan was also the first Soviet republic to create its own State Property Committee and began privatization of state enterprises in 1991 before independence. The Government of Kazakhstan has been quick to adopt models of reform from international experience, including a health insurance system based on Russia's system and a pension reform scheme modeled on reforms in Chile. The Government has also been quick, however, to abandon such experiments, often before implementation has progressed significantly enough to mature and be evaluated objectively. This dynamic environment and readiness to try, and just as quickly abandon, new policies has created opportunities for innovation, but more often has led to an unstable policy environment that inhibits more than encourages the risk-taking that is often needed for reform.

Another distinguishing characteristic of the policy environment in Kazakhstan is a high level of decentralization and regional autonomy. The degree of decentralization, which has always been strong in Kazakhstan, was further entrenched by a series of new laws and regulations passed since the beginning of 1999. With these trends in the devolution of policy and budget authority to the oblast and regional level, Kazakhstan is opting away from a national health care system and toward more variation in financing and service delivery policies. The highly decentralized system means that there is no clear, coherent health sector strategy, but it can also mean that there

are often fewer barriers to reform at the oblast level even when commitment to reform is uncertain at the national level.

III. History Of Health Sector Reform

The history of health reform in Kazakhstan dates back to the 1989 NEM demonstration during Soviet times. Although the NEM demonstration was cancelled in 1990, some general principles of reform had taken root in Kazakhstan. In 1992, the government of newly independent Kazakhstan established three oblasts as new health sector demonstration sites: Zhezkazgan, South Kyrgyzstan, and Kokchetau. Under the new demonstration program, an area in Zhezkazgan Oblast that was also designated as a free economic zone, began a health insurance experiment in 1993. To establish an alternative source of financing for the health sector, the President of Kazakhstan extended the health insurance experiment nationwide in June 1995. These events coincided with the start-up of the ZdravReform Program in late 1994.

A. From Intensive Demonstration Site to Targets of Opportunity

The original ZdravReform Program design and implementation plan led the ZdravReform Program to initially concentrate its technical assistance in an Intensive Demonstration Site (IDS). The IDS in Kazakhstan was determined to be South Kyrgyzstan Oblast based on the MOH designation of this oblast as a health reform demonstration site in 1992. Although this oblast had a history of experimentation with health reform, there were nonetheless political obstacles to implementing a comprehensive health reform program. Therefore, after a year of concentrating resources in the IDS with limited success, ZdravReform began to modify its implementation strategy from the IDS approach to one of following “targets of opportunity.” Under this modified approach, technical assistance was provided to oblasts that had already demonstrated real commitment and initial steps to undertake reforms.

Zhezkazgan Oblast became the first oblast to request ZdravReform assistance to further its health reform initiative under the new implementation strategy. In 1995 when the Government of Kazakhstan extended the small-scale insurance experiment in a region of Zhezkazgan to the entire oblast, Zhezkazgan became the first oblast in Kazakhstan to finance health care facilities through the MHI Fund. With the introduction of health insurance, the Zhezkazgan health sector leadership seized the opportunity for fundamental restructuring of health care service delivery and financing. In June 1995, local officials in Zhezkazgan invited ZdravReform to observe the health reform process and make recommendations for technical assistance. ZdravReform began working with the Oblast Health Department and the Mandatory Health Insurance (MHI) Fund to refine and expand new provider payment systems, restructure service delivery, embark on privatization, and create a truly integrated package of health reforms.

Less than one year later, Semipalatinsk Oblast also approached the ZdravReform Program for assistance to implement the health reform program that was approved by the Oblast government in December 1995. In Semipalatinsk Oblast a unique combination of reform-minded local administrative officials and an influx of international technical and material assistance created an environment conducive to rapid and innovative reform. Following ZdravReform workshops and training seminars on health insurance implementation issues, the Oblast Health Department and MHI Fund jointly requested ZdravReform assistance in February 1996. When the Federal MHI Fund granted Semipalatinsk status as a pilot oblast in April 1996, ZdravReform developed a plan for comprehensive technical assistance to the Oblast.

Over two years, the ZdravReform Program concentrated its resources in these two demonstration sites. The initial results were quite rapid, because the policy environments in these oblasts were highly conducive to reform, and the health sector labor force was prepared for and receptive to change. Both Zhezkazgan and Semipalatinsk Oblasts had progressive leadership and a long history of being on the forefront of policy experiments. In addition, the highly decentralized government system in Kazakhstan allowed oblast leadership to adopt a pace of reform that was more accelerated than national reforms.

In both oblasts, primary health care reforms were the centerpiece of the reform package. PHC restructuring was carried out, and clinical strengthening of the new PHC practices was begun. At the same time, new economic incentives were created for health providers with the implementation of per capita payment for primary health care in both oblasts, and a case-based hospital payment system in Zhezkazgan. Information systems were established, and modern management techniques introduced. In both oblasts, primary health care practitioners from the new practices organized non-governmental associations, which were active in policy dialogue and instrumental in helping to carve out the new role for primary health care in the system.

B. Oblast Mergers and Move to the National Level

In 1997, Zhezkazgan Oblast was merged with neighboring Karaganda Oblast, and Semipalatinsk was merged with East Kazakhstan Oblast. The new oblast centers were located in Karaganda and East Kazakhstan, which led to an abrupt change in the health sector leadership in Zhezkazgan and Semipalatinsk. Nearly one year of the program in Kazakhstan was spent salvaging the demonstrations in Zhezkazgan and Semipalatinsk. The effect of the oblast merger highlights both the risks and the benefits of a demonstration strategy.

Over the next year, ZdravReform continued activities in the new oblasts, but many of the reforms were stalled or reversed completely following the oblast merger. ZdravReform devoted significant time to policy dialogue with the new leadership to protect the health reform demonstrations. In Zhezkazgan, the reforms have been protected and expanded into all of Karaganda Oblast, which is now a prominent and innovative leader in health reform in Kazakhstan. In Semipalatinsk, the rural reforms were weakened by the oblast merger, and the demonstration site was reduced to Semipalatinsk city and two surrounding rayons. This situation has recently begun to change with the new World Bank health sector loan, which became effective in August 1999. USAID committed to collaborate with the World Bank, with ZdravReform providing technical assistance to implement the World Bank-financed project. The World Bank loan initially designated Semipalatinsk Oblast as one of the project sites because of the health reform progress already achieved there. The World Bank-financed project combined with ZdravReform technical assistance is now serving as a catalyst to expand the Semipalatinsk reforms throughout East Kazakhstan Oblast.

In many ways, the oblast merger facilitated, or even forced, the movement of the ZdravReform Program from oblast level demonstrations to expanding activities to the national level. This happened in part because the political obstacles following the oblast merger made it difficult to continue activities in the demonstration oblasts at the previous intensity. In addition, the former head of the Zhezkazgan Oblast Health Department and long time ZdravReform counterpart, Tolebai Rakhimbekov, became the chairman of the Committee on Health in the Ministry of Health, Education and Sport.

Experience working at the national level showed, however, that the oblast merger forced the ZdravReform Program to shift the focus to national roll-out prematurely. The conditions were

not fully in place for national level roll-out of the reforms in Kazakhstan for several reasons. First, the national Committee on Health, having been reduced from the level of a Ministry, did not have adequate capacity and resources to embark on a national level implementation effort. Second, the existing demonstrations were not entirely mature, and the need remained for continued technical support from ZdravReform at a relatively intensive level. Finally, the other oblasts of the country did not have the necessary conditions in place to implement reforms without significant technical assistance. These oblasts, therefore, had difficulty implementing national reform legislation, which often discredited the reform initiatives themselves in these oblasts.

Therefore, while the convergence of events, both programmatic and political, allowed the ZdravReform Program to break through previous barriers and make significant inroads into national level health reform in 1998, it became necessary to return to the oblast level and continue to build the technical foundation for a slower-paced, more sustainable national roll-out of reforms. The foundation building for national activities includes deepening the reforms in the leading oblasts to create innovations that can be used in other oblasts, and the start-up of reforms in other oblasts to create the conditions necessary for national roll-out.

III. Results

Over the past five years, the ZdravReform Program has worked with the Government of Kazakhstan to create the legal and regulatory basis necessary to support health sector reform, and to develop, test and roll out working models of PHC-centered health reform. Even in the unstable policy environment discussed above, significant progress has been made in each of these areas. The following sections summarize results at the national level and in the demonstration sites in each of the four technical program components: 1) developing national policy and legal framework for reform; 2) strengthening primary health care; 3) increasing health care financing and improving resource allocation; and 4) ensuring population involvement and choice. These results were achieved through the evolving ZdravReform program implementation strategy to adapt to the needs of this dynamic and decentralized policy environment, and often variable level of commitment to health sector reform at the national level.

A. National Policy and Legal Framework

Because of the rapidly changing policy environment in Kazakhstan, policy dialogue and technical assistance to monitor and provide input into the legal and regulatory basis for health reform has been a significant and resource-intensive activity in the Kazakhstan country program. The ZdravReform legal team has been instrumental in identifying key areas of policy dialogue, providing technical review and recommendations for draft laws and regulations, and serving as an important source of information and analysis for counterparts in the oblast demonstration sites to keep them apprised of the frequent changes in national policies, laws and regulations and their implications for the demonstration programs.

ZdravReform has provided input into numerous health sector laws and regulations, improving their technical content and the feasibility of implementation. The ZdravReform Program has provided most significant assistance to improve the laws and regulations governing health financing and the flow of health care funds. The most recent iteration of these laws reflects ZdravReform recommendations and is expected to remove many of the previous barriers to financing health care facilities according to new provider payment systems. The ZdravReform Program also has provided technical assistance and analysis to the process of designing the legal basis for a defined health care benefits package and regulations on user fees.

Other specific laws that have been enacted that reflect ZdravReform recommendations include the 1996 “Law on Tuberculosis” and the law on “Compulsory Treatment of Patients with Tuberculosis.” ZdravReform also provided assistance to amend and improve the presidential edict “On Pharmaceuticals,” which begins to create the basis necessary to implement rational pharmaceutical management activities and a drug reimbursement scheme in the future.

In addition to providing analysis and input into national laws and regulations, the ZdravReform Program also has provided assistance in the policy, legal and regulatory area to the oblast demonstration sites. An important contribution has been to analyze and draft reports on specific legal topics that have confusing and contradictory implications for the oblast demonstration activities. For example, when oblast officials were considering privatization as an option for primary health care restructuring in Zhezkazgan and Semipalatinsk, the laws and regulations were complicated, contradictory, and open to wide interpretation. The ZdravReform Program prepared a report analyzing the implications and shortcomings of the existing legal and regulatory documents related to privatization. The report was distributed to oblast counterparts as well as national officials, and contributed to the suspension of privatization of health facilities until more clear regulatory guidelines could be established.

ZdravReform also provided specific assistance to the newly independent PHC practices in the demonstration sites and newly formed health sector NGOs in the areas of incorporation, taxation, and labor relations. ZdravReform’s comprehensive analysis of laws and regulations on corporations and incorporation enabled family physicians in new PHC practices to make more informed decisions about whether and how to incorporate, and how to achieve the most favorable tax status. In addition, a ZdravReform document analyzing labor laws, provided PHC practice owners and managers with crucial information to exercise greater flexibility in their staffing decisions and personnel management.

Finally, the ZdravReform Program has encouraged and supported the development of health sector NGOs to give individual providers and patients a new voice in the health policy process. Family Group Practices have organized themselves into nongovernmental professional associations, which are active in policy dialogue and instrumental in carving out a new role for primary health care in the health care system. Professional associations have also been established by family medicine trainers and pharmaceutical sector professionals. There are now 5 ZdravReform-supported NGOs actively working as advocates for health sector change in Kazakhstan.

B. Strengthening Primary Health Care

Efforts to restructure the primary health care delivery system in Kazakhstan, as in the other countries of Central Asia, have focused on creating a network of PCH practices that are financially, administratively and sometimes physically independent from higher level facilities. The ultimate goal of these restructuring efforts is to increase the managerial autonomy and internal control that primary health care providers have over their resources, so they can better adapt their services to the needs of their populations. These independent practices are then strengthened through clinical training and equipment so they can expand their scope of services, including integrating vertical programs such as family planning, tuberculosis, and other infectious diseases. The following sections provide greater detail about the process and achievements in PHC strengthening in Kazakhstan.

1. PHC Restructuring

In Kazakhstan, various models of PHC restructuring have been tested, including urban and rural models, physical co-location in polyclinics and separate physical structures located in the community, and private and government ownership. The key principles that are maintained in all of the models is that the entire population is covered by PHC practices that have greater financial and management autonomy and are strengthened clinically to expand their scope of services. All of the 453 PHC practices in the demonstration sites in Kazakhstan are registered as independent legal entities, so they are legally permitted to have their own bank accounts, which allows the PHC practices to be financed directly rather than through polyclinics and hospitals.

In urban areas, the first step to primary health care restructuring has been reorganizing polyclinics and women's consultation centers into mixed polyclinics that serve both adults and children, and that also provide women's reproductive health services. The next step of establishing the managerial and financial independence of the primary health care providers has typically meant physically separating them from the polyclinic structure, although some PHC practices have been registered as independent entities while still located in polyclinics in Semipalatinsk city, Karaganda, and Ust-Kamenogorsk.

The urban PHC practices are staffed by therapists, pediatricians, gynecologists, nurses, and a practice manager. In Zhezkazgan/Satpaeva and Semipalatinsk cities, the group of primary health care specialists was trained (and they continue to cross-train each other) to become general or family practitioners. The practice manager is a new position that has been introduced to help the PHC practices begin to function more like businesses and to free head physicians from burdensome administrative work, so they can spend more time in clinical practice. The practice managers are instrumental in operating new health information systems and assisting the head physician to use the information for better decision-making. The ZdravReform Program provided training for all of the practice managers in Zhezkazgan/Satpaeva, and led a three-month intensive training course for the 30 new practice managers in Semipalatinsk.

A model of rural PHC restructuring was tested in Semipalatinsk Oblast, and is now being expanded throughout the demonstration oblasts. Because PHC providers in rural areas are already physically separated from hospitals and polyclinics, and the PHC system is not as fragmented as in urban areas, the existing physical PHC structure has been simply reorganized administratively and financially. To form rural PHC practices, the SVA and FAP system is being consolidated into SVA/FAP complexes, with a unified catchment area and a single budget. The rural PHC practices are staffed by physicians, though typically not the full complement of therapists, pediatricians and gynecologists, and a practice manager, which may be shared with one or more other PHC practices. As in urban areas, the rural PHC practices are registered as legal entities so they can have their own bank accounts. There are currently more than 300 rural PHC practices in the ZdravReform demonstration sites in Kazakhstan.

With the exception of those in Zhezkazgan city, all of the newly formed PHC practices in urban and rural areas have remained government institutions. In Zhezkazgan, the network of PHC practices was privatized over a period of two years, and all practices are now owned by the family physicians that manage them. The financing of these private practices is still almost entirely from public sources, however, and according to their contracts with government financing bodies, they provide all primary health care services to the population free of charge.

2. Expanded PHC Scope of Services

The restructuring of the primary health care delivery system, particularly in the rural areas, is one of the least resource-intensive steps in the reform process, and therefore has often been implemented quite rapidly. To be effective in shifting resources and service delivery to the PHC sector, however, it is essential that restructuring be followed by the more difficult and resource-intensive step of clinical strengthening. In Kazakhstan, the ZdravReform Program has devoted significant resources to clinical strengthening, including clinical training, small grants to nongovernmental PHC associations to purchase equipment, and the integration of vertical programs into the primary health care scope of services.

The ZdravReform Program has collaborated with the Kazakh Postgraduate Institute of Physicians to train hundreds of physicians and nurses through a two-month intensive course in family medicine. ZdravReform has followed the intensive family medicine training with targeted supplemental training in specialty areas that are important for family physicians, such as cardiology and gynecology. In addition, clinical training has been provided in specific areas to support the integration of vertical programs into the PHC scope of services. In the last six months of 1999 alone, ZdravReform sponsored seven intensive training courses to train more than 400 physicians in ARI/CDD, reproductive health, pediatrics, cardiology, and sexually transmitted infections (STIs).

In the Zhezkazgan and Semipalatinsk demonstration sites, the strengthening of PHC has been one of the most important ongoing program activities, and the integration of vertical programs into PHC has progressed significantly in these demonstration sites. In Zhezkazgan, the integration of reproductive health services was advanced tremendously with a pilot program to integrate the diagnosis and treatment of sexually transmitted infections into the scope of services of PHC practices. The ZdravReform Program led a coordinated effort to design and launch the pilot, which represents the first time ever in the former Soviet Union that the diagnosis and treatment of STIs is being decentralized to the level of primary health care. Implementation of this ongoing pilot began in November 1999, after extensive collaborative planning with the Kazakhstan National STI Research Institute, the Zhezkazgan Regional Health Department (RHD), the Zhezkazgan Family Group Practice Association (FGPA), WHO and UNAIDS-funded University of Heidelberg. The STI pilot is being supported by the ZdravReform Program and other donors with clinical training, drugs and supplies, and an intensive population information and education campaign.

To integrate the management of infectious diseases into PHC, ZdravReform also supported the pilot test and adaptation of the WHO protocol for the integrated management of childhood illnesses (IMCI) for the Central Asia and NIS region. Semipalatinsk city and two surrounding rayons was chosen as one of two sites to test and adapt WHO IMCI protocol, and to integrate IMCI into primary health care. The ZdravReform Program has supported this pilot intensively through clinical training in ARI/CDD, immunizations, nutrition, maternal and perinatal health, rational pharmaceutical management, health management systems, and surveillance. The ZdravReform Program also has coordinated with other donors, such as WHO and the World Bank, to secure the necessary drugs for the IMCI pilot.

In addition to clinical training, the ZdravReform Program has supported clinical strengthening of new PHC practices by providing limited amounts of basic equipment to the practices through the nongovernmental PHC practice associations. The Program provided technical assistance to develop appropriate equipment lists and awarded small grants to associations in Zhezkazgan, Semipalatinsk, and Ust-Kamenogorsk to purchase equipment. The ZdravReform Program has

also collaborated closely with the World Bank to provide a more substantial base of equipment for PHC practices in all of East Kazakhstan Oblast through the World Bank-financed Health Sector Project.

3. *Current Status*

There are currently more than 450 independent PHC practices in the two demonstration sites and roll-out oblasts in Kazakhstan. In Zhezkazgan and Semipalatinsk cities, 100 percent of the population is covered by an independent PHC practice. Primary health care restructuring based on the Zhezkazgan and Semipalatinsk models is successfully being rolled out to East Kazakhstan Oblast, in collaboration with the World Bank, and to Karaganda Oblast.

In 1998, the restructuring of the PHC delivery system was incorporated into national policy through a decree of the national Committee on Health (Prekaz 500). This decree mandated that all rural and urban PHC providers be separated administratively from higher level facilities. Although this decree was a positive step, because it provided the legal basis for national roll out of the PHC restructuring, the national health leaders attempted to implement the decree too quickly without adequate preparation, information and support for oblast health officials and PHC physicians. The pressure to restructure the system too rapidly has created some opposition to PHC restructuring and reopened the debate in Kazakhstan about the most appropriate structure for primary health care service delivery. The vision of a PHC-centered health care system, however, has become an integral part of Kazakhstan's health policy agenda. And while the national policy debate continues, oblast and city health officials throughout Kazakhstan are continuing to restructure their PHC delivery systems, and the Postgraduate Institute for Physicians is reaching a growing number of physicians outside of the demonstration sites requesting clinical training in family medicine. The core principles of PHC strengthening supported by the ZdravReform Program will therefore be relevant under any design of the health care system that Kazakhstan eventually chooses.

C. *Health Care Financing and Resource Allocation*

ZdravReform assistance in health financing and resource allocation often has been driven by the volatile changes in the national policy in health financing over the past five years, but the underlying model and goals have remained consistent. The Program has provided assistance to improve the use of health care resources by creating a single purchaser of health care services that has the authority to pool funds at the oblast level and distribute payments to health care facilities without budget chapters according to new payment systems. In order to design and implement these new financing policies, the ZdravReform Program has directed significant technical resources to developing health information systems for both the purchasers and providers of health care. The program has also provided assistance directly to health care providers to improve their management and resource utilization decisions. The following sections describe the major challenges and achievements in improving health financing policy and resource use in Kazakhstan over the past five years under the major national health financing regimes.

1. *Health Insurance*

When the ZdravReform Program began in late 1994, the new mandatory health insurance system was about to be signed into law and was therefore the main focus for program activities in health financing. Before the health insurance system was implemented, ZdravReform argued for a single-payer system, under which the insurance fund would become the single purchaser of health care. The Government of Kazakhstan, however, ultimately opted to adopt the Russian model of

health insurance, which created overlapping financing responsibilities for the Ministry of Health (MOH) and Mandatory Health Insurance (MHI) Fund. This institutional structure with a multi-payer system made it difficult to realize many of the potential gains of the insurance system. The dual benefits package and unclear financing responsibilities made conflict between the MOH and MHI Fund inevitable, which, among other factors, eventually contributed to the re-incorporation of the MHI Fund into the Ministry of Health, Education and Sport (currently Agency for Health Care) at the end of 1998.

Even given the obstacles presented by the institutional structure and the inexperience of the MHI leadership, however, the MHI system did serve as an instrument for change in the health care system in Kazakhstan. The MHI Fund was an eager counterpart for the ZdravReform Program, and made use of the combination of a new mandate and the availability of technical assistance to introduce change. Thus, innovations in provider payment systems, computerized information systems and quality assurance were introduced by the MHI Fund between 1995 and 1998. In addition, the opportunities presented by the off-budget status of the MHI Fund at least brought the concepts of pooling of funds and chapterless financing into the health policy debate.

The advantages of the health insurance system were realized most successfully in the ZdravReform demonstration sites. Unlike in most oblasts, in Zhezkazgan and Semipalatinsk Oblasts, the relationship between the MHI Fund and Oblast Health Departments was cooperative, and the ZdravReform Program was therefore able to work with health leadership to seize the momentum of the health insurance system. Rapid progress was made in these oblasts in restructuring the delivery system together with the implementation of new provider payment and information systems.

Although the re-incorporation of the MHI Fund into the Agency for Health Care (AHC) in 1999 did again create a single-payer system, there were unintended consequences that have created difficulties for health financing reform. With the termination of the MHI system, all government health care financing was returned to the budget, and is again subject to the control of local finance departments. Returning all health financing to the budget has enormous implications for health financing reform initiatives because: (1) there is no longer an earmarked tax for health care, which may threaten the overall level of funds available for health care; (2) health care financing is being returned to the level of budget administration (rayon, city and oblast), and therefore oblast level pooling of funds is more difficult; and (3) the Ministry of Finance and treasury stringencies are reintroduced into the allocation of funds across health care institutions and across expenditure categories within health care institutions.

2. *GosZakaz*

In 1999, following the closure of the MHI Fund, the Government of Kazakhstan attempted to preserve some of the efficiency incentives that were achieved under the new provider payment methods of the health insurance system by expanding the role of a competitive procurement mechanism, GosZakaz. GosZakaz, which was previously used only in very limited ways for health care, is a loosely defined contracting mechanism that allows government financing bodies to enter into contracts with public and private providers of goods and services on a competitive basis. The terms of the competition are subject to wide interpretation and definition by oblast administrations, but GosZakaz contracts are required to specify the price per service and the maximum volume of services to be provided for a year. This regulation, which directly contradicts the implementation of incentive-based provider payment systems, has caused provider payment reforms to slow or be reversed in some places. The ZdravReform Program provided

extensive assistance to redraft the regulations so that GosZakaz is implemented in a way that is consistent with new provider payment systems.

3. *Current Status*

In spite of the unstable policy environment, with three different national health financing systems since 1998, the ZdravReform Program has made significant achievements in health financing and management in Kazakhstan over the past five years. Nearly 50 percent of health care providers are paid by new provider payment systems in the five ZdravReform sites in Kazakhstan, and 27 percent of providers are using modern management techniques. Most recently, national legislation was enacted that will remove many of the barriers to expanding and refining new provider payment systems.

Currently, the health financing system is again being reconsidered in Kazakhstan, and health insurance may be reintroduced. The ZdravReform Program has actively participated on working groups to analyze policy options, and has contributed several analytical documents to the debate. The Program presented guidelines for a strategic planning approach to health financing reform and completed an analysis of international experience with health insurance systems, including the first experience with health insurance in Kazakhstan. It is unclear which path Kazakhstan will choose for its health financing system. The ZdravReform Program, however, has built capacity, provided analytical and technical tools, and contributed to legislation that together create a strong foundation for the continuation of financing reforms. New provider payment systems have been developed and refined, and new health information systems are operating in the demonstration sites. The foundation that is in place increases the probability that whichever new financing system Kazakhstan chooses will preserve the fundamental concepts of new health provider payment methods, and information and management systems that increase the effectiveness of limited health care resources and shift power to individual providers and patients.

D. *Population Involvement and Choice*

In the Soviet system, the population had limited rights as well as limited responsibilities for their own health care. They were unable to choose their primary health care provider, and their health care provider did not provide them with information. One of the goals of health reform is to empower the population to take a more active role in their health care decision-making. Increasing population involvement requires redefinition of both population rights and responsibilities. Therefore, as in all of the Central Asia ZdravReform country programs, increasing the rights and responsibilities of the population for their own health care through information and choice has been a central component of the Kazakhstan program. The following sections describe the major activities and achievements in the area of choice (open enrollment), and information (health promotion and population awareness).

1. *Open Enrollment*

A central change that is necessary to increase population rights and responsibilities is to give patients effective choice of their health care provider. If provider payment systems allow the money to follow the patients' choices, strong economic incentives are created for providers to change their behavior to be more responsive to patients.

The ZdravReform Program has encouraged free choice by supporting open enrollment campaigns in which the population is given a fixed period in which to enroll in the PHC practice of their choice. Open enrollment campaigns in Zhezkazgan/Satpaeva and Semipalatinsk have given the

population the right to choose their primary health care provider for the first time ever. In Zhezkazgan 85% of the population has actively enrolled in the PHC practice of their choice. Several re-enrollment campaigns also have been held in Zhezkazgan to give the population the opportunity to periodically change their primary health care provider if they are not satisfied or feel they can get better service elsewhere. Open enrollment campaigns based on the Zhezkazgan model have also been held in Satpaeva and Semipalatinsk cities. Health officials from both Karaganda and East Kazakhstan Oblasts are eager to replicate the experience in the demonstration sites and conduct primary health care open enrollment in their oblasts.

2. Health Promotion

For patients to exercise effective choice, they must be informed about the health care system and their own health. An important aspect of this component of the health reform model, therefore, is to raise public awareness about the health care system and provide information about health topics to the public to take responsibility for their own health. An important element of the ZdravReform Kazakhstan country program, therefore, has involved the development and dissemination of products to raise public awareness about health reforms and provide information to the public to take responsibility for their own health.

In addition to routinely incorporating population information and awareness activities into the work of the comprehensive health reform demonstrations, ZdravReform developed specific health information and communication products and activities. For example, ZdravReform produced two-minute videos on such topics as family planning, ARI/CDD, tuberculosis, STIs, cardiovascular disease, and safe motherhood. These videos were aired on television channels throughout Kazakhstan. The ZdravReform Program also sponsored journalist contests to promote the dissemination of health messages on important public health topics through the routine work of mass media. The journalist contests received entries from journalists throughout Kazakhstan on tuberculosis, childhood infectious diseases, and reproductive health. Overall, the ZdravReform Program has also increased health awareness throughout the population with more than 500 video spots, 200 newspaper articles, 200 radio spots and journalism contests, all covering health topics that are important to assist the population to take greater responsibility for their own health.

IV. Conclusion and Lessons Learned

As discussed above, although Kazakhstan has presented a somewhat unstable environment for health sector reform over the past five years, significant achievements have been made. The Kazakhstan country program has therefore yielded important lessons for health systems development in a dynamic and unstable context.

First, one of the major factors contributing to the success of ZdravReform during this time of great change in Kazakhstan has been the underlying conceptual health systems development model that has remained relevant regardless of the changes in leadership, decentralization, and different paths chosen in health financing policy. The specific strategies for implementing the model could be adapted over time and across sites according to the political context. The conceptual model also provided general guidance to health sector leaders in the demonstration sites, even when they were receiving conflicting messages from the national health policy debate.

Second, Kazakhstan is clearly moving away from a national health care system, and is instead opting for more regional variation in health financing and service delivery policy. Experience from the ZdravReform Program in Kazakhstan has shown that decentralization may be beneficial

for some aspects of health systems development. For example, decentralization can be helpful for accelerating oblast demonstration where oblast leadership is more progressive and ready for change than national leaders. Experience has also shown, however, that it remains important for the national level to establish a broad policy and legal framework for the health care system. Kazakhstan has made steps toward deepening some components of the health reform model by institutionalizing them with national legislation. Examples include national level legislation that provides the foundation for implementing a case-based hospital payment system and restructuring primary health care. More work is needed, however, on a more comprehensive policy and regulatory framework to guide the overall development of the health care system.

Finally, the successes in the Kazakhstan ZdravReform country program were achieved where the program was able to focus on building fundamental capacity that is required for the reforms to be sustainable, and that is less likely to be affected by changes in leadership. Experience from the Program has shown that for successful capacity-building, it is important that the pace of reforms follow a natural progression of foundation-building and step-by-step implementation. If reforms are pushed too quickly by top-down planning and legislation, implementation gets ahead of capacity, and local partners become frustrated and are unlikely to claim ownership of the reform process. This outcome was witnessed when the Chairman of the Committee on Health in Kazakhstan attempted to restructure primary health care change provider payment systems too quickly. The greatest successes in Kazakhstan were achieved where reforms were implemented gradually and allowed to follow a natural process of expansion, so that capacity-building was driven by demand from local partners.

Kyrgyzstan Final Report

I. History

A. Introduction

As the history of the Kyrgyzstan reforms provides context for the program activities and results of the ZdravReform Program over the last two years, a brief summary is included in this report. Health reforms began in Kyrgyzstan in mid-1994 with the designation of Issyk-Kul Oblast as the national health reform demonstration site and the WHO-supported development of a national health reform plan termed the MANAS Program. From late 1994 to late 1996, the USAID-funded ZdravReform Program developed and implemented a comprehensive, integrated health reform model in Issyk-Kul Oblast. Positive results obtained in Issyk-Kul Oblast facilitated development of a productive collaboration between the World Bank and USAID. In 1997, the World Bank and the USAID-funded ZdravReform Program collaborated to roll-out the Issyk-Kul health reform model to Bishkek City and Chui Oblast. Also in 1997, the ZdravReform Program was able to begin the process of institutionalizing health reform at the national level. In 1998, ZdravReform began the long process of rolling-out the health reform model to Osh and Jalal-Abad Oblasts in South Kyrgyzstan.

One of the reasons for the success of health reform in Kyrgyzstan is the development and implementation of a comprehensive, integrated health reform model that addresses the problems of the health sector. While operational strategies and plans have varied with the rapidly changing environment, the basic health reform model has remained the same. It has provided stability in an uncertain environment and guided the path of reform. There are four main components of the health reform model: 1) health delivery system restructuring and strengthening primary health care; 2) population involvement; 3) new provider payment systems; and, 4) new management information systems. Developing a legal and policy framework for reform and raising public awareness are elements of each of these components.

B. Issyk-Kul Oblast Demonstration Site

Issyk-Kul Oblast was chosen as the national health reform demonstration site in mid-1994 by the Ministry of Health (MOH) of Kyrgyzstan. In late 1994, health reforms were initiated with a series of training seminars introducing various concepts, including health delivery system restructuring, health management, health insurance, accreditation, and cost accounting. By summer of 1995, a ZdravReform Office had been established, staffed by an expatriate resident advisor and local staff. The site office worked intensively on building a foundation and implementing the health reform model in Issyk-Kul Oblast over the next two years, supported by technical staff from the Almaty Regional Office. In mid-1997, the health reforms, though still fragile and unsustainable, had taken root and the process of widening or roll-out through collaboration with the World Bank had begun.

C. Design of the First World Bank Health Sector Reform Project

Kyrgyzstan designed and implemented the first World Bank Health Sector Reform Project in Central Asia. Many of the design assumptions and parameters from this project have carried over into the World Bank Projects currently being implemented (Kazakhstan and Uzbekistan), and designed (Tajikistan) in Central Asia.

As the Kyrgyzstan Health Sector Reform Project was the first in Central Asia, the World Bank strived to establish a balance between addressing the MOH's critical short-term health and humanitarian needs, and developing a more efficient, sustainable health delivery system for the long-term. The initial stages of design in early 1995 brought only limited success in finding this balance. For example, the Ministry of Health (MOH) wanted the project to provide drugs. While the World Bank recognized and wanted to address this need, they also wanted to invest in improving the efficiency of the health delivery system to increase long-term sustainability.

In mid-1995, discussions between the USAID-funded ZdravReform Program and the World Bank design team contributed positively to establishing this balance. World Bank senior health advisors were impressed with the design of the Issyk-Kul Oblast demonstration and wanted to extend the health reforms to Bishkek City and Chui Oblast as a component of the World Bank Health Sector Reform Project. Including roll-out of the Issyk-Kul Oblast health reform model into the project provided the balance that allowed project design to move forward.

Over the next year, the ZdravReform Program contributed substantial technical assistance to the design of the first World Bank Health Reform Project in Kyrgyzstan. When the project became effective in late 1996, ZdravReform began to collaborate with the World Bank Health Reform Project in the roll-out of the Issyk-Kul health reform model to Bishkek City and Chui Oblast.

D. Crisis Surrounding the Role of Health Insurance

Extension of the health reforms to the national level was hampered by a crisis concerning the role of health insurance and the new Health Insurance Fund (HIF) in the health sector of Kyrgyzstan. On the positive side, resolution of this issue triggered the process of institutionalizing the health reforms at the national level.

The initial World Bank position was that health insurance was irrelevant to the World Bank Health Reform Project. However, it was ZdravReform's contention that introducing a new health purchaser into the health sector would have an enormous impact on the implementation of new provider payment systems, one of the core elements of the project. When health insurance was introduced and the Health Insurance Fund established in late 1996, the World Bank Project was stopped in order to resolve this issue and avoid the problems experienced by Russia and Kazakhstan.

The introduction of health insurance and the establishment of a new Health Insurance Fund as second health purchaser in addition to the MOH created many problems in Russia and Kazakhstan. For example, health policy was not coordinated between the MOH and HIF and health sector functions were duplicated increasing administrative costs. Restructuring the health sector was difficult because two provider payment systems created contradictory financial incentives, and two benefit packages created inequity and confusion among the population. Providers were incapable of managing payment from two sources, and fraud and abuse increased.

In the winter of 1997, the ZdravReform Program, together with the World Bank and Kyrgyz counterparts developed a new concept, approved by the Government in mid-1997, called the Coordinated Policy for the Implementation of Health Reform and Health Insurance. This policy introduced MOH and HIF Jointly Used Systems to enable the MOH and HIF to function as a single-payer in the health sector while remaining as separate institutions with separate sources of financing. The MOH and HIF Jointly Used Systems consisted of five systems – information, provider payment, accounting, quality assurance, and benefits coordination.

The MOH and HIF Jointly Used Systems functioned very well in the initial stages of health reform and over the next year the reforms in Kyrgyzstan progressed rapidly because the MOH and HIF coordinated health policy in an effective manner.

II. Program Activities and Results from the ZdravReform Program Option Period

The health reforms in Kyrgyzstan have continued to progress rapidly over the last two years. The following sections provide an overall summary of accomplishments; describe the roll-out of the Issyk-Kul Health Reform Model to Bishkek City and Chui Oblast through collaboration between USAID and the World Bank; describe the initial stages of institutionalization of the health reforms at the national level; describe the initial stages of roll-out of the Issyk-Kul Health Reform Model to Osh and Jalal-Abad Oblasts; describe the initiation of the foundation-building stage in Naryn and Talas Oblasts; describe the role of Kyrgyzstan as a regional leader in health reform; and give some specific program results.

A. Summary of Accomplishments

Kyrgyzstan continues to move forward implementing all the components of the health reform model. Over 400 new Family Group Practices (FGPs) have been established nationwide to strengthen primary health care. Clinical training has been provided to FGP physicians and nurses in Issyk-Kul Oblast, Bishkek City, and Chui Oblast, and to FGP physicians in the four pilot areas of Osh and Jalal-Abad Oblasts through the national Family Medicine Training Center (FMTC) in Bishkek City and FMTC Affiliates in Issyk-Kul and Osh Oblasts. Training of course is an ongoing process and needs to be continued.

A national Family Group Practice Association has been established in Bishkek City as an NGO with affiliates in Issyk-Kul, Osh, and Jalal-Abad Oblasts. A national Hospital Association has been established in Bishkek City as an NGO with affiliates in Osh and Jalal-Abad Oblasts. These NGO's have advocated and provided services to their respective members, FGPs and hospitals. In addition, they have contributed to the development of civil society and a democratic transition in Kyrgyzstan as increased power in decision making about health care can contribute to the desire for more democratic participation in other sectors of the economy.

The health reforms have involved the population in decisions about their health care by redefining both population rights and responsibilities. One new right of the population is the right to choose their primary health care provider. In Issyk-Kul Oblast, Bishkek City, and Chui Oblast, approximately 80 percent of the population has exercised this right by voluntarily enrolling in the FGP of their choice. In addition to new rights, the population also has new responsibilities, particularly responsibility for their own health status. The ability of the population to manage and improve their own health status is being enhanced through extensive health promotion campaigns.

New provider payment systems contribute to economic restructuring by introducing competition, increasing health sector efficiency, and allowing health providers increased management autonomy to allocate resources more effectively. A new case-based hospital payment system was developed in Issyk-Kul Oblast and implemented nationally by the Health Insurance Fund (HIF). Over 60 hospitals or almost all the general hospitals in the country now are receiving part of their revenue under this new case-based hospital payment system. A new hospital information system was developed to support this hospital payment system and more than 800,000 hospital cases have been paid nationwide using this information system.

New capitated rate payment systems in which FGPs are paid a capitated rate per enrollee have been developed and implemented. The national HIF has contracts under this new capitated rate system, paying over 400 FGPs in Issyk-Kul Oblast, Bishkek City, Chui Oblast, and Osh and Jalal-Abad Oblasts. Issyk-Kul Oblast has also implemented this new FGP payment system using budget or general revenue funds as well as health insurance funds. A licensing and accreditation function has been established nationwide, requiring that hospitals and FGPs be licensed and accredited before being eligible to contract with the HIF.

New clinical and financial management systems for health providers have been developed and implemented. A December 1998 MOH prekaz cancelled old health statistics forms and replaced them with new clinical information forms, codes, and automated information systems that are being introduced in stages nationwide. New clinical protocols, health purchaser quality assurance systems, and health provider quality improvement techniques are being developed and implemented. Finally, a legal framework is being established to institutionalize the health reforms.

Implementation of all the components of the health reform model continues throughout Kyrgyzstan. It is important to note that Kyrgyzstan has adopted a very process oriented, step-by-step approach to health reform. A national MOH and HIF Joint Working Group develops health reform strategy that outlines both a broad vision and operational plans containing a series of steps required to realize this vision. Incremental steps are introduced which strengthen the foundation and produce small victories which lead to larger victories.

The MOH in Kyrgyzstan has been successful in coordinating and integrating contributions from a multitude of donors including USAID, the World Bank, WHO, the British Know How Fund, GTZ, the Swiss Development Agency, and the Asian Development Bank. The collaboration between USAID and the World Bank has been particularly fruitful. The World Bank was impressed by the Issyk-Kul Oblast health reform demonstration and began the process of widening the demonstration by including a roll-out of the health reform model to Bishkek City and Chui Oblast in the first World Bank Project. USAID provided technical assistance to support this roll-out to Bishkek City and Chui Oblast. A second World Bank Project is currently being developed to extend the health reforms nationally and continued technical assistance from USAID will increase the probability of national roll-out of the Issyk-Kul health reform model and sustainability of the health reforms.

Many of ZdravReform's Central Asia program strategies have been developed and tested in Kyrgyzstan, including criteria for a successful demonstration project and the demonstration widening or roll-out process; collaboration with the World Bank; the contribution of health reform to economic restructuring and democratic transition; development of a successful regional program; and integration of infectious diseases and reproductive health into primary health care to increase sustainability and health sector efficiency. In addition, Kyrgyzstan has contributed many "lessons learned" which inform and improve the health reform process throughout the Former Soviet Union.

B. Issyk-Kul Oblast Demonstration Site

The major accomplishments of the Issyk-Kul Oblast demonstration are summarized as follows:

- ? 81 new Family Group Practices were formed in stages from early 1995 through mid-1996. From June 1998-June 2000, the legal status of FGPs was solidified and technical assistance and training largely succeeded in establishing FGPs as the foundation of a new health

delivery system structure. Though an evolutionary process reflecting increased autonomy at the FGP level, FGPs voluntarily merged to combine resources such that Issyk-Kul Oblast currently has 74 FGPs.

- ? FGPs were strengthened through the provision of family medicine training for FGP physicians and nurses in Issyk-Kul Oblast from 1996 through the present. The Family Medicine Training Center in Issyk-Kul Oblast is institutionalized as an affiliate of the Post-Graduate Institute's National Family Medicine Training Center.
- ? From June 1998-June 2000, FGPs began to incorporate infectious diseases and reproductive health into primary health care.
- ? A new health sector NGO, the Family Group Practice Association (FGPA), was established in 1996. From June 1998-June 2000, the FGPA established a voluntary board structure and developed their capabilities to provide services to their member FGPs.
- ? Over 85% of the population was enrolled in FGPs as a result of intensive marketing campaigns held in stages over the last half of 1996. From June 1998-June 2000, the population database based on enrollment was strengthened and used as the basis for capitated rate payment to FGPs.
- ? From June 1998-June 2000, extensive health promotion campaigns on a variety of health topics were held using mass media (television, radio, and newspapers) and other channels such as information brochures and community meetings.
- ? From June 1998-June 2000, institutional capacity-building and development of the Oblast Health Insurance Fund resulted in the existence of an entity capable of serving as a health purchaser.
- ? A new case-based hospital payment system was developed in Issyk-Kul in 1996 and became the basis of the National Health Insurance Fund hospital payment system initiated in late 1997. From June 1998-June 2000, the oblast hospital and all Central Rayon Hospitals in Issyk-Kul were paid under the new case-based hospital payment system.
- ? In the fall of 1998, the National Health Insurance Fund (HIF) tested a new capitated rate payment system for FGPs in Issyk-Kul Oblast. All 74 FGPs in Issyk-Kul are now being paid under this new HIF system. In 1999, the National HIF extended this FGP capitated rate payment system to all FGPs nationwide.
- ? In 1998, a new FGP capitated rate payment system for budget funds was developed and tested in Issyk-Kul.
- ? New health information systems for both the health purchaser and health provider were developed, tested, implemented, and refined in Issyk-Kul Oblast and later implemented at the national level.
- ? A new health sector career was established and developed – practice managers for FGPs.
- ? A policy and legal framework for health reform was developed.

While the Issyk-Kul Oblast demonstration has been a success, experience has shown that continued support is necessary for a number of reasons. First, although the basic ZdravReform Program Central Asia health reform model was fairly well established by 1995, lessons learned from implementation have ensured that operational strategies continued to evolve. Many of the early adjustments to the model were developed in the Issyk-Kul Oblast demonstration. For example, it became crystal clear that health delivery system restructuring and changes in health financing were not sufficient to drive health reform. The basic nature of clinical practice must be changed. This resulted in a shift in focus of the ZdravReform Program that has continued to this day, emphasizing family medicine clinical training.

Second, in the early stages, the health reforms were very fragile and not sustainable. For example, while Issyk-Kul Oblast had successfully formed 81 new primary health care entities

called Family Group Practices (FGPs), their role in a health sector dominated by hospitals was still uncertain. Until the FGPs were strengthened and their scope of service expanded, resources and service provision could not be transferred from hospital care to more cost-effective primary health care. In addition, infectious diseases and reproductive health that had been treated through a specialized system now had to be incorporated into primary health care in order for the system to become more cost-effective. In other words, though restructuring the health delivery system and building a new, more efficient primary health care sector is vital to the success of health reform, the roles and relationships between primary health care, outpatient specialty care and inpatient care must also be redefined.

Third, the process of rolling-out the Issyk-Kul health reform model to the entire country of Kyrgyzstan required continued visible success and lessons learned from the Issyk-Kul Oblast demonstration. Health reformers in other parts of Kyrgyzstan needed Issyk-Kul Oblast to convince an entrenched and unprogressive health sector that health reform was necessary and a positive change. This situation continues to the present day.

A final reason why continued support for the Issyk-Kul demonstration site is necessary is that health reform is a step-by-step process where many subsequent steps are built on the foundation established in prior steps. For example, until FGPs are strengthened through clinical training, the scope of services they provide to the population cannot be expanded and solidified by the financial incentives of new provider payment systems. Also, health authorities are understandably reluctant to grant FGPs more management autonomy until their capabilities have improved. Many of these subsequent steps are now being realized in Issyk-Kul.

In summary, the Issyk-Kul Oblast demonstration site both triggered the health reform process in Kyrgyzstan and serves as an on-going impetus for health reform by continuing to identify and overcome barriers to reform.

C. Roll-Out of the Health Reform Model to Bishkek City and Chui Oblast

In early 1997, experienced local staff were relocated from Issyk-Kul to Bishkek in order to establish an office and begin implementation of health reform in Bishkek City and Chui Oblast in collaboration with the World Bank. The World Bank Project procured technical assistance from Abt Associates. However, the amount of technical assistance the Kyrgyz Government was willing to borrow for was minimal and substantial ZdravReform inputs were required to implement the project. This situation is illustrative of the foundation of the World Bank and USAID collaboration – USAID brings technical assistance the government does not want to borrow for and the World Bank brings substantial investment in commodities and political leverage.

The roll-out of health reforms to Bishkek City and Chui Oblast moved rapidly. By late 1999, 108 FGPs had been formed in Bishkek City and 144 FGPs had been formed in Chui Oblast. As of June 2000, the task of strengthening FGPs is proceeding well as FGPs have received equipment, renovations, and clinical training. In late 1998, over 80% of the population of Bishkek City and Chui Oblast, more than one million people, exercised their right of free choice of primary health care provider and enrolled in the FGP of their choice. Health promotion campaigns began to increase the responsibility of the population for their health status. National health sector NGOs, the Family Group Practice Association and Hospital Association, were established, and their capability to advocate and provide services to their members increased. New provider payment systems and health information systems were developed, tested, and implemented under the HIF.

As in Issyk-Kul, health reform in Bishkek City and Chui Oblast has taken root, but is not yet sustainable. Progress continues under the USAID and World Bank collaboration to strengthen the health reform.

D. Institutionalization of Health Reform at the National Level

A process-oriented approach was established at the national level to develop the policy and legal framework for health reform and a step-by-step approach to implementation. A MOH and HIF Joint Working Group was established to develop health policy, strategies, and operational plans. Technical Joint Working Groups were also established to address issues such as clinical information, provider payment, pharmaceuticals, and quality assurance. The Joint Working Group process was very successful in developing a health policy framework.

Work began to establish a legal framework based on the health policies developed by the MOH and HIF Joint Working Group. Many pieces of the legal framework have been put in place over the last few years. For example, national FGP regulations, Health Insurance Fund organization and provider payment regulations, regulations for health information systems, and important government decrees such as reinvestment of savings in the health sector have been approved. However, much more work is needed, particularly in the areas of allocation of budget funds, continued restructuring of the health sector, and clinical practice.

In addition to establishing a policy and legal framework for implementation of health reform at the oblast level, many elements of health reform were also implemented at the national level. As Kyrgyzstan is a small country, it was decided that many of the provider payment systems and health information systems could be implemented nationally.

In late 1997, the Health Insurance Fund began implementation of a new national case-based hospital payment system. Over 60 hospitals, or almost all the general hospitals in Kyrgyzstan, are currently being paid under this system. In 1998, the Health Insurance Fund began contracting with FGPs as they were formed, paying them through a capitated rate payment system.

Extensive health information systems have been developed and are being implemented at the national level. In December 1998, a MOH prekaz cancelled many of the old health statistics forms, replacing them with forms and systems developed by the ZdravReform Program. This was a major step on the road to sustainability. While the new health information systems developed by ZdravReform operated the new provider payment systems, contributed to quality assurance and research, and provided better data for decision-making for both health purchasers and health providers, the new information systems were running parallel to the old systems. Relinquishing the old system allows the new health information system to develop more rapidly and cost-effectively.

As discussed above, Kyrgyzstan made extremely rapid progress in the implementation of health reform from early 1997 through mid-1998. However, in mid-1998, progress slowed as political events resulted in a break-down of the coordinated MOH and HIF health policy. This lack of coordination of health policy between the MOH and HIF led the MOH to recognize that it was time to establish a health sector institutional structure viable in the long-term.

In December 1998, Kyrgyzstan took another major step forward by merging the HIF under the MOH to create a single-payer in the health sector. The MOH and HIF Jointly Used Systems had bought time and allowed the health reforms to progress rapidly by avoiding the problems faced

by Russia and Kazakhstan. However, the pace of reform had slowed significantly because of the inability of the MOH and HIF to coordinate policy.

There are several reasons why a single-payer is the most appropriate health purchaser institutional structure in Kyrgyzstan. First, it allows the major advantage of the Soviet system to be retained – universal coverage with relatively equal access and equity for the population. A multi-payer system on the other hand segments the population and inevitably results in unequal access, usually for vulnerable populations.

In addition, a single-payer allows a single institution to have control over all the parameters or elements of health reform. In implementing health reform in the Former Soviet Union (FSU), changes in health financing and provider payment systems are necessary, but not sufficient. The structure of the health delivery system also has to change. A single-payer can restructure the health sector as well as introduce new provider payment systems. In addition, the single-payer can address issues ranging from setting broad health policy, to improving clinical practices and quality, to establishing and improving health information systems.

In summary, Kyrgyzstan has taken major steps toward institutionalizing health reform at the national level and enhancing sustainability in the long-term. Kyrgyzstan, along with all FSU countries, faces enormous hurdles in restructuring the health sector to provide lower cost, higher quality health services to the population. Kyrgyzstan's step-by-step approach has allowed the country to keep moving forward in health reform, identifying and removing hurdles along the way. However, the job is not finished and there are many important obstacles that still need to be addressed.

Beginning the process of institutionalizing the health reforms at the national level facilitated the on-going process of rolling-out the health reform model across oblasts. The next section discusses roll-out to South Kyrgyzstan.

E. Roll-Out of the Health Reform Model to Osh and Jalal-Abad Oblasts

In early 1998, the MOH requested assistance from USAID to begin the process of rolling-out or extending the health reforms to South Kyrgyzstan – Osh and Jalal-Abad Oblasts. As South Kyrgyzstan is large, containing approximately 50% of the population, it was decided to roll-out in stages using pilot sites. There are currently four pilot sites in South Kyrgyzstan. Osh Oblast pilot sites are Aravan and Now-Kat Rayons. Jalal-Abad pilot sites are Jalal-Abad City and Bazaar-Korgon Rayon.

Similar to the World Bank collaboration, the USAID-funded ZdravReform Program developed a collaboration with the Asian Development Bank (ADB). The ADB has designed a Social Sector Project in South Kyrgyzstan, focusing on health and education. The project has been delayed, but is expected to become effective soon. In health, the ADB Project will focus on rural infrastructure. It will provide equipment and renovations for newly formed FGPs in rural areas. The Osh and Jalal-Abad Family Group Practice Associations will be involved in decisions concerning equipping and renovating rural FGPs. It is expected that the second World Bank Project planned to start in 2001 will finish equipping and renovating urban FGPs.

From June 1998-June 2000, ZdravReform has worked with counterparts in Osh and Jalal-Abad to establish the Family Group Practice Association and Hospital Association as health sector NGOs serving as vehicles for health reform, formed 64 FGPs, and provided clinical training for more than 300 FGP physicians. ZdravReform also has initiated health promotion campaigns targeting

the population, collected and analyzed health sector data, facilitated the implementation of national provider payment systems, and developed and implemented new health information systems.

Although the health reforms in Osh and Jalal-Abad Oblasts have been initiated very rapidly, much work remains. The health reforms in the pilot sites need to be deepened and then widened or rolled-out throughout South Kyrgyzstan. In addition, the health reforms need to be integrated into the ADB Project when it finally becomes effective.

F. Initial Stages of Roll-Out to Naryn and Talas Oblasts

Institutionalization of health reform in a national policy and legal framework has resulted in the initialization of the first stages of health reform in the two remaining Kyrgyzstan oblasts of Naryn and Talas. Starting in the fall of 1999, the ZdravReform Program contributed to developing the pre-conditions for health reform in Naryn and Talas by starting to establish Family Group Practice Associations, forming FGPs, beginning to collect data for analysis, and beginning to include participants in training seminars.

III. Role of Kyrgyzstan as a Regional Health Reform Leader

The role of Kyrgyzstan in triggering health reform in other Central Asian countries should not be underestimated. The countries of Central Asia still face the same problems in their health sectors. They look to each other for new interventions and also to learn from experiences and avoid mistakes.

Countries including Russia, Ukraine, Mongolia, Tajikistan, Kazakhstan, Uzbekistan, and Turkmenistan have sent representatives for site visits of the Kyrgyz reforms. Tajikistan in particular has been influenced by the health reforms in Kyrgyzstan. The Central Asian countries are requesting more regional seminars such as the health reform conference held in Issyk-Kul Oblast in the summer of 1999. Kyrgyzstan is a leader in health reform in Central Asia -- it keeps raising the bar and setting a standard that influences the health reform process in other countries.

IV. Impact Of Health Reforms on Health Sector Efficiency in Kyrgyzstan

Two exemplary impacts of the health reforms on the efficiency and effectiveness of the health sector are presented below.

A. Hospital Length of Stay

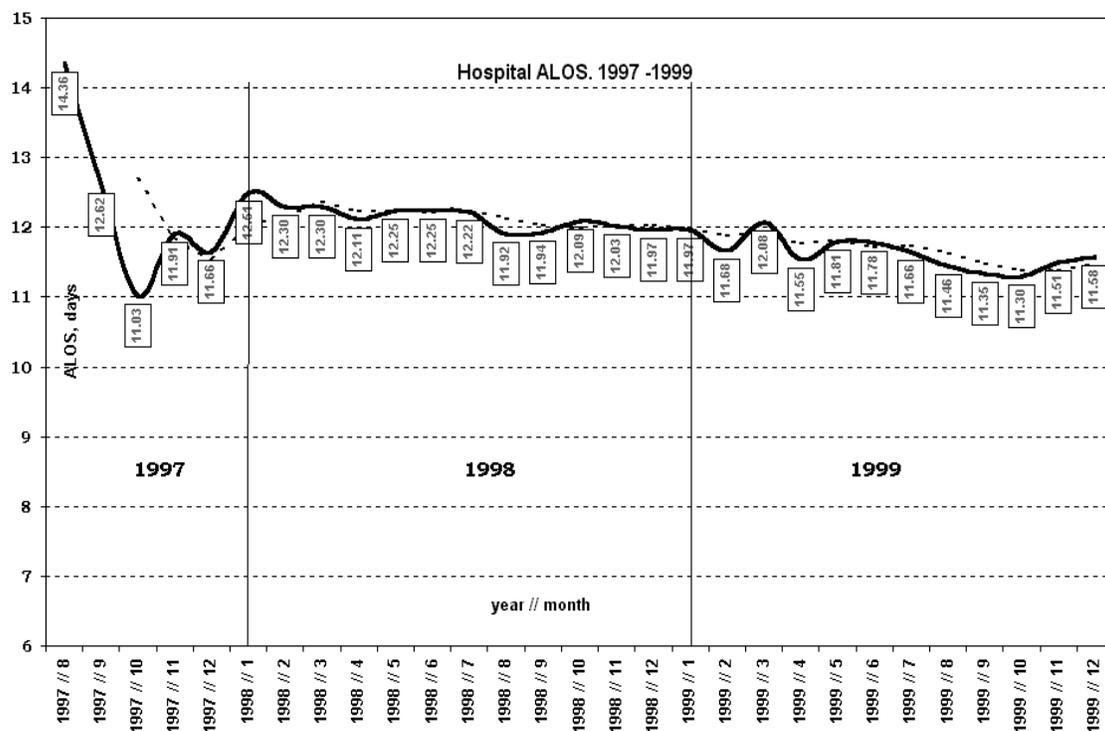
The health delivery system in Kyrgyzstan resembles an inverted pyramid. The hospital sector is overdeveloped, containing massive amounts of excess capacity. Therefore, it is very inefficient, consuming more than 70% of health sector resources. Primary health care is the most cost-effective health service, but it is underdeveloped and needs to be strengthened. One objective of health reform is to strengthen primary health care (through the formation of new primary health care entities called Family Group Practices) and shift resources from inpatient or hospital care to primary health care.

The old hospital payment system was a budget system that allocated funds based on production input measures such as number of beds. It contained a direct financial incentive to increase and maintain capacity. The result is a health service delivery system with too many hospitals and too many beds. A new case-based hospital payment system was introduced in Kyrgyzstan to contribute to the

rationalization of the hospital sector and a shift of resources to the more cost-effective primary health care sector. The hospital payment system creates competition among hospitals and allows them more management autonomy to allocate resources more effectively.

One indicator of hospital efficiency is length of stay (LOS), the average number of days each patient remains in the hospital. The LOS in Kyrgyzstan is approximately three times higher than the United States. The old hospital payment system contained financial incentives to increase LOS, while the new case-based hospital payment system contains financial incentives to decrease LOS.

A national case-based hospital payment system was implemented in Kyrgyzstan in August 1997 by the Health Insurance Fund (HIF). Approximately 60 general hospitals throughout Kyrgyzstan are now being paid under this new hospital payment system. The chart below shows the change in LOS across these 60 general hospitals over the last two and one half years, from implementation of the hospital payment system in August 1997 through December 1999. The source of information is the hospital payment information system developed and implemented by the HIF with technical assistance and training from the ZdravReform Program. By December 1999, it contained over 600,000 hospital cases which represent bills submitted for each hospital case in order to receive payment.



The average LOS in the 60 general hospitals included in the new case-based hospital payment system has decreased from 12.61 days in January 1998 (the point at which it is considered that enough hospitals and cases were contained in the system for it to be representative) to 11.58 days in December 1999 – a decrease of 8 percent. More importantly than the absolute decrease is the stability of the trend, there has been a stable and consistent decrease in LOS since the implementation of the new hospital payment system by the HIF.

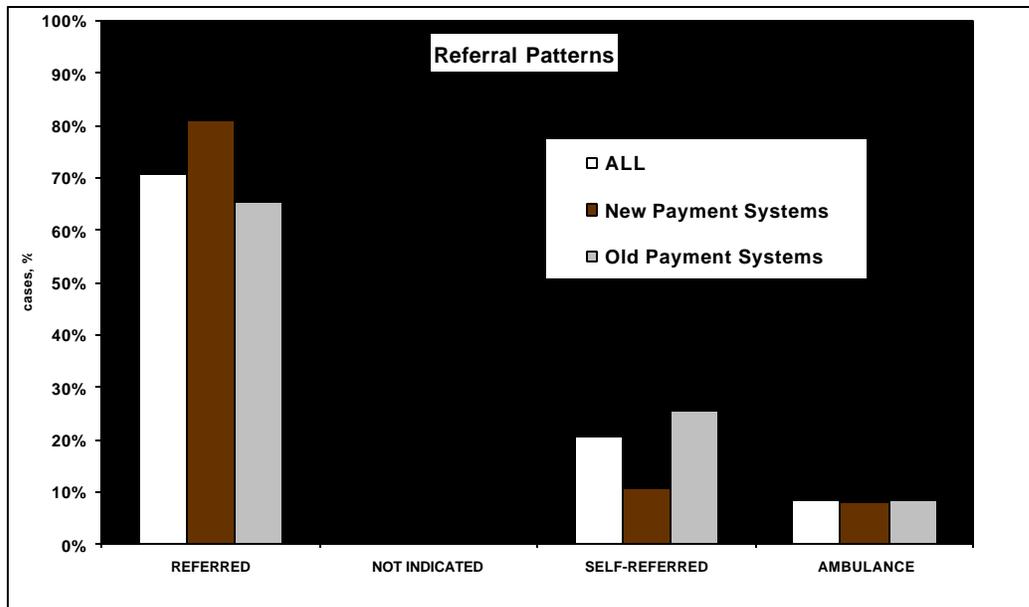
This decrease in LOS means that hospitals are functioning more efficiently, creating savings that can be reinvested in improved health services for the population. While the decrease in LOS does not result in realization of savings until hospitals rationalize or downsize their capacity, the competition and management autonomy created by the new hospital payment system encourages hospitals to undertake this rationalization.

B. Primary Health Care Referrals

One way to evaluate the impact of health reform on health delivery system effectiveness is the level of referrals from primary health care to other levels of the health delivery system. While primary health care is the most cost-effective level of service, the primary health care sector in Kyrgyzstan is underdeveloped and needs to be strengthened. FGPs are being formed to strengthen primary health care and expand its scope of service, meaning that medical conditions formerly treated in hospitals can be treated in FGPs. The level of referrals indicates whether primary health care is expanding its scope of service.

To effectively strengthen primary health care, the health delivery system must be strengthened and financial incentives introduced through new provider payment systems to encourage health providers and the population to utilize primary health care services. These financial incentives to guide utilization of health services are being introduced in Kyrgyzstan through the new case-based payment system for hospitals and the new capitated rate payment system for FGPs.

The Health Insurance Fund introduced a policy into its new case-based hospital payment system affecting how the health delivery system is utilized. Hospital cases would not be paid unless the patient was referred to the hospital by a FGP or other outpatient provider. This policy and the attached financial incentive strongly encourages the population to use primary health care services rather than self-refer to hospitals. The combination of strengthening primary health care and introducing financial incentives to utilize primary health care results in a more efficient health sector providing lower cost, higher quality health services to the population.



The impact of the Health Insurance Fund policy concerning self-referral is shown by the referral chart. The hospital payment database containing 486,000 cases through August 1999 is the source of referral data. The clinical information form or bill contains mandatory information on the source of referrals to the hospital.

The sources of referral in this chart are referral from a FGP or other outpatient provider, self-referral meaning that the patients refer themselves to the hospital, and ambulances. Under the new hospital payment system, the level of self-referrals dropped from 25.63% to 10.64% over the time period from August 1997 to August 1999. This is a 58% drop in the rate of self-referrals meaning that patients are utilizing primary health care more often and the health delivery system is beginning to function more effectively.

I. Introduction

Large-scale health reform efforts focusing on strengthening primary health care and emergency care are currently being carried out in Uzbekistan by the Ministry of Health, with financial support and technical assistance from the World Bank-financed “Health” Project, the USAID-funded ZdravReform Program, the British Know How Fund, and others. The implementing institutions coordinate their activities through a national Steering Committee and working groups for each technical component of the project.

The primary responsibility of USAID’s ZdravReform Program is to provide technical assistance to the Government of Uzbekistan to support implementation of the rural primary health care reform program in three pilot rayons in Ferghana oblast. To date, 45 primary health care facilities (12 *sel’sky vrachebny punkty* (SVPs) and 33 *sel’sky vrachebny ambulatory/feldsher-akusher punkty* (SVA/FAP complexes)) have been registered as independent juridical entities that receive financing directly from the Oblast Health Department on a per capita basis. The health reforms piloted in Ferghana oblast will serve as a model for extension to the rest of Ferghana oblast and to Navoi and Syr Darya oblasts under the “Health” Project, and, ultimately, will determine the direction of national primary health care reform.

In the two years that ZdravReform has worked intensively in Uzbekistan, the program has made significant strides in implementing health reforms in Ferghana oblast. As in Kazakhstan and Kyrgyzstan, health reform efforts in Uzbekistan have been guided by the ZdravReform regional health reform model, adapted for implementation in rural areas in Ferghana oblast, as well as a 1996 governmental order on rural infrastructure development and a 1998 presidential decree to reform the health system. Over the course of the past two years, ZdravReform provided technical assistance to: 1) Develop a legal and regulatory framework for health reform and monitor and evaluate reform progress; 2) Introduce new payment, management, and health information systems for primary health care facilities; 3) Strengthen clinical capacity of primary health care facilities and personnel; and 4) Provide targeted health promotion activities and small grants to involve the community in improving their own health and the health system.

II. Legal and Regulatory Framework for Health Reform

Over the past two years, ZdravReform has provided technical assistance to develop a legal and regulatory basis for health reform, monitored reform progress and informed the health policy development process, and started to train key policymakers.

ZdravReform provided legal analysis, advice, and/or assistance in drafting legislation supporting the health reform project, including a Cabinet of Ministers resolution on implementing primary health care reforms in Ferghana oblast. Together these documents provide the legal basis to:

- ? Form a network of juridically independent primary health care institutions in three experimental rayons of Ferghana oblast (Beshariq, Quva, and Yazyavan)
- ? Increase the proportion of oblast health care funds allocated to primary health care
- ? Pool primary health care funds for the three experimental rayons in Ferghana oblast at the level of the Oblast Health Department

- ? Finance all independent juridical primary health care entities in the three experimental rayons according to a single per capita rate
- ? Add the position of financial manager to the SVP and SVA/FAP complex staff schedules
- ? Authorize drug procurement for primary health care facilities without need for large tenders
- ? Create additional staff positions (economist, accountant) at the Oblast Health Department to focus solely on supporting new financing systems
- ? Adopt hiring criteria for new and replacement Financial Managers
- ? Reduce the number of budget chapters from 20 to 4, providing positive first steps towards greater autonomy and independence for health facilities

ZdravReform also supported the establishment and ensured the registration as independent juridical entities of 45 SVPs and SVA/FAP complexes in the three experimental rayons. ZdravReform was instrumental in convincing policymakers to include all primary health care facilities, not only SVPs, in the new financing and management systems. This will be crucial to show an impact on the efficiency and effectiveness of the primary health care system as a whole.

A health reform monitoring and evaluation strategy currently is being developed to report on health reform progress and inform health policy development. The strategy is based on the stated goals and objectives of the reform program, and a conceptual framework that demonstrates how the new policies are expected to lead to the desired outcomes. Since the “Health” Project was designed with experimental and control rayons, evaluation can be made both across points in time and across matched “case-control” sets of rayons. The monitoring and evaluation strategy draws on existing administrative information sources, the new health management information system that is being introduced, and periodic surveys that provide more comprehensive information across points in time in the reform process.

To date, ZdravReform has:

- ? Collected baseline information from a series of 18 focus groups with the population and health care workers to determine initial attitudes towards primary health care
- ? Conducted a survey of more than 25,000 primary health care encounters to compile a snapshot of initial primary health care service delivery and utilization patterns in SVA/FAP complexes and SVPs
- ? Conducted a health facility survey in the 83 primary health care facilities in the six experimental and control rayons in Ferghana oblast to provide baseline information on the organization and management of the facilities, the material resources of the facilities, and basic knowledge among health care workers about some key treatment protocols
- ? Collected information from over 1200 households in six experimental and control rayons to evaluate the impact of health reforms on many of the dimensions of the health and well-being of the population, such as the level of underlying chronic illness and out-of-pocket payments, that are not captured by administrative data

In addition, and often in close partnership with USAID’s Global Training for Development (GTD) Project, ZdravReform facilitated training abroad and in Uzbekistan for senior-level policymakers in order to enable them to take a more active role in leading and supporting health sector reform efforts.

- ? In June 1999, ZdravReform and GTD sent three participants from Uzbekistan to the United States for a two-week regional study tour to examine the management of health information systems in the U.S., with additional focus on financial management of health care

organizations and insurance companies. The study tour included discussions of how centralized information systems at the Health Care Financing Administration and in other large medical institutions are used for provider payment, medical statistics, quality assurance, and research. Participants particularly enjoyed site visits where they were able to see how information systems are integrated into the overall health care system and at the facility level and are used for more informed decision-making and more effective resource allocation.

- ? In February 2000, ZdravReform designed a one-week study tour on General Practice to Great Britain for six senior-level policymakers from the Ministry of Health that included lectures, discussion, and site visits to rural primary health care clinics outside of London.
- ? In March 2000, ZdravReform sponsored a site visit of a Ministry of Health representative to Zhezkazgan, Kazakhstan to learn more about primary health care reform and privatization efforts in urban areas in that oblast and present findings and a proposal to the Ministry of Health for how the information collected can be used to improve health reform efforts in Uzbekistan.
- ? In May 2000, ZdravReform served as the training provider for another GTD-financed event, a two-day national seminar entitled “Lessons Learned and Next Steps in Training General Practitioners.” The seminar brought together undergraduate and post-graduate General Practitioner (GP) trainers from Tashkent Institute for Advanced Medical Education, the six regional medical institutes, ZdravReform’s short courses, as well as family medicine specialists and trainers from Great Britain, the U.S., Russia, Estonia, Kazakhstan, and Kyrgyzstan to share experiences and lessons learned and to make recommendations for improvement, integration, and institutionalization of GP training programs in Uzbekistan.
- ? In June 2000, ZdravReform designed a study tour to Bishkek and Karakol, Kyrgyzstan for five “Health” Project representatives from the Central Project Implementation Bureau and Oblast Project Implementation Bureaus in Navoi and Syr Darya. The goal of the study tour was to allow participants to share experiences so that they could identify ways to improve implementation of health reform efforts in Uzbekistan and improve the legal and policy framework for reform efforts to better institutionalize reforms. Participants seemed especially interested in how the functions of purchasers and providers of health care services were more clearly delineated in Kyrgyzstan as well as ways to increase monetary incentives for health personnel by more rational utilization of facility resources. In addition, they were impressed by quality control systems and the integration of various vertical programs and levels of the health system into a more general and functional system.

III. New Payment, Management, and Health Information Systems for Primary Health Care

In addition to supporting the development of a legal framework for the reforms and assisting in the establishment and strengthening of primary health care facilities, the ZdravReform Program and the “Health” Project were successful in implementing new payment and management systems for the facilities, based on capitation. The new systems have the dual goals of increasing the resources allocated to primary health care, while at the same time providing incentives to use those resources more efficiently.

1. New Payment Systems

In early 1999, discussions were held with officials from the Ferghana oblast Central Bank and the Oblast Finance Department to determine a mechanism for disbursing primary health care capitated budgets according to business plans developed by the facilities. Under the previous system, budgets were allocated according to strict, centrally planned budget chapters. The

representatives from the oblast financial sector agreed to accept business plans in place of chapter budgets for internal allocation of primary health care resources.

The first phase of developing the per capita payment system included the following steps: 1) calculation of the pool of funds available for primary health care in Ferghana oblast based on the calculation formula in Postonovleniye #100; 2) pooling of primary health care funds for the three experimental rayons at the Oblast Health Department and pro-rating them from April to December 1999; 3) dividing the pool of funds by the total number of people in the catchment areas of the 45 primary health care facilities to get a single per capita rate; 4) developing budgets for each facility by multiplying the capitated rate by the population in the catchment area; and 5) developing business plans to determine the allocation of capitated budgets across budget chapters. Funds began to flow under the new system on April 1, 1999.

New Payment Systems Increase Funds and Management Autonomy for Primary Health Care Facilities

As a result of constructing a new primary health care budget pool to set the capitated rate, the share of the per capita oblast budget for primary health care increased from 11 percent to 20 percent for the three experimental rayons between 1998 and 1999. The average per capita rate in the three experimental rayons increased from 225 sums in 1998 to 365 in 1999 and increased again during 2000 to 667 sums. In 1999, the Ministry of Finance collapsed the standard twenty budget chapters for independent legal entities to four main chapters (salaries, social fund contributions, capital investments, and other expenditures), granting primary health care facilities more flexibility to use their resources in a more cost-effective way.

The second phase of implementing the per capita payment system included the following steps:

- ? Conducting a survey of more than 25,000 primary health care encounters in Ferghana oblast to better understand the services that are being provided in the primary health care sector, how resources are currently being allocated, and how utilization of health care services varies by the characteristics of the population
- ? Calculating the capitated rate and primary health care budgets for the year 2000 for 45 primary health care facilities in the three experimental rayons in Ferghana oblast, including providing assistance to develop sex and age adjustment coefficients
- ? Supporting an increase in the capitated rate from 365 to 667 sums based on an expected expansion in the scope of services provided by primary health care facilities
- ? Finalizing the selection and grouping of coefficients to adjust the capitated rate in these rayons based on the sex and age of their respective populations together with the Oblast Health Department
- ? Assisting the Oblast Health Department to finalize the year 2000 budgets for each primary health care facility and to revise facility budgets to include sex and age coefficients in June 2000

In early spring 2000, ZdravReform in coordination with the “Health” Project conducted seminars in Navoi and Syr Darya oblasts to share experiences and lessons learned from health system development in Ferghana oblast and to introduce new reform stakeholders and counterparts at oblast and rayon levels to rural primary health care reform efforts, with a special emphasis on implementing new financing, management, and information systems.

2. New Management Systems

ZdravReform and its partners also succeeded in developing new management mechanisms to support the new provider payment systems. In November 1998, ZdravReform provided technical assistance to the Oblast Health Department and the Oblast Bureau of the “Health” Project in hiring Financial Managers to be located in SVPs and SVA/FAP complexes in Ferghana oblast. These Financial Managers will help to manage the facilities under the new payment system.

ZdravReform provided a three-month training program for the Financial Managers on business planning, modern accounting practices, management information systems, marketing strategies, and health statistics. In February 1999, at the end of training, 15 Financial Managers were tested and certified, giving them the right to work as Financial Managers in the SVPs and SVA/FAP complexes in the three experimental rayons. Financial Managers were assigned to serve multiple SVPs and SVA/FAP complexes based on the size of the population served and began to work in their facilities on April 1, 1999. With technical assistance from ZdravReform and the Oblast Health Department, Financial Managers have worked with head doctors of SVPs and SVA/FAP complexes to develop business plans and chapter budgets for 1999 and 2000.

Since hiring and training the initial 15 Financial Managers, ZdravReform has provided technical assistance to improve the process of hiring, training, and supporting the Managers to help implement new provider payment systems. The “Health” Project, with assistance from ZdravReform and in coordination with oblast health authorities, developed guidelines for hiring new and replacement financial managers, using experience and lessons learned from hiring the initial group of financial managers. These guidelines have been added to Ministry of Health Prikaz 169 guiding the implementation of financing and management reforms. In December 1999, using the new guidelines, a committee from the Oblast Health Department, with assistance from the “Health” and ZdravReform Projects, hired six new Financial Managers from two rayons, bringing the total number of Financial Managers to 21.

ZdravReform also has been working over the past two years to develop a viable and sustainable model for training new financial managers assigned to primary health care facilities. Initially an intensive, three-month training focusing on introducing health management topics, basic accounting, and computer skills was envisioned. The training would end in testing and certification of financial managers, followed by their reporting to primary health care facilities. As ZdravReform discovered, preparing a large pool of new financial managers through an intensive training program was necessary as a first step in laying a foundation for the introduction of financing and management reforms. Over time, however, a more flexible and modular system for ongoing training and certification became necessary to deal with attrition as well as the hiring of new financial managers. The ongoing training will consist of an intensive one-week introductory course, followed by a number of modular courses, each lasting 1-3 days and offered once a month to all financial managers, as new or refresher training. Trainings would consist of a combination of lectures, discussion, case studies, and exams. Upon completion of the entire series of modular courses, new financial managers will be certified.

In November 1999, ZdravReform conducted seminars for the 15 existing Financial Managers on business planning, the Uzbek Labor Code and regulations concerning staff, and new accounting systems for independent budget organizations. A follow-up seminar to complete facility business plans for 2000 was held in late December. Also in December, ZdravReform with support from the Oblast Health Department, conducted a one-week introductory training for the six new Financial Managers, including modules on the health reform model in Uzbekistan, an introduction to financing and management changes under the reforms, and local accounting

standards. For these courses, ZdravReform developed five modules for Financial Management training on primary health care reforms, health financing and payment systems, basic accounting, business planning and budgeting, and general administration and human resource management.

ZdravReform continually monitors the work of the Financial Managers and is ready to assist in problem solving as needed. During the last year, this support has included:

- ? Hiring a ZdravReform coordinator based in Ferghana to support the work of the Financial Managers, identify problem areas, work with the Oblast Health Department and the “Health” Project to design and implement appropriate solutions, and assist in on-the-job training for Financial Managers
- ? Holding weekly meetings with Financial Managers in each rayon to facilitate their work and provide assistance in solving problems
- ? Collecting and analyzing monthly facility expenditures from Financial Managers
- ? Donating 15 bicycles to facilitate the travel of financial managers between the primary health care facilities in which they work
- ? Collaborating with Peace Corps Health Management Volunteers to draft a reference manual in Uzbek for Financial Managers and Head Doctors in SVPs and SVA/FAP complexes that was distributed in June 2000
- ? Providing a copy of the Uzbek Labor Code to each Financial Manager

3. Health Management Information Systems

Simultaneously with the development of the new provider payment and health management systems, ZdravReform began to develop a new computerized health information system for Uzbekistan based on the information system being used by the Kyrgyzstan health reform program. The essence of the new approach to clinical data collection and processing, proposed by ZdravReform, is to streamline data collection, collecting only information that is relevant and essential for data analysis. Two databases comprise the information system: a population database and a clinical information database. The population database includes basic individual and family demographic information and will also track births, deaths, and migrations, which is important information both for the implementation of a per capita payment system, and for monitoring the effects of the reform program on individual health services utilization and health status. The clinical information database will provide information to the Oblast Health Department and primary health care facilities on clinical utilization, including visits, referrals, and diagnoses.

In early 1999, ZdravReform and the “Health” Project developed new clinical and financial information forms for the new information system, established procedures for completing the forms, and defined the flow of information necessary to create a comprehensive population database for Ferghana oblast. The Ministry of Health and the Oblast Health Department approved these materials. ZdravReform and the Oblast Health Department then worked with health personnel in 45 facilities in the three experimental rayons and 38 facilities in the three control rayons in Ferghana oblast to complete population enrollment forms for the estimated 800,000 people in the catchment areas of these 83 facilities.

At the end of May 1999, ZdravReform oversaw the arrival of a server and 20 computers procured by the “Health” Project for the new Ferghana Oblast Computer Center that was set up in the Oblast Health Department Office of Medical Statistics. After assisting in completing renovations to the Oblast Computer Center, ZdravReform installed and networked the server and 20 computer work stations in July 1999 and installed the population database software. Since the computers were installed in July, ZdravReform has:

- ? Hired 37 temporary data entry operators to enter information on the demographic structure of the catchment area of each SVP and SVA/FAP complex in the experimental and control rayons of Ferghana oblast
- ? Paid data entry operators on a per form basis to encourage rapid entry
- ? Entered over 630,000 records into the population database from 83 primary health care facilities in six rayons (original catchment area population estimates of 800,000 were inflated)
- ? Created a “TestKey” program to routinely check the accuracy of data entry
- ? Provided assistance to the “Health” Project to prepare Rayon Computer Centers and to distribute computers from the Oblast Computer Center to the Rayon Centers in February and March 2000
- ? Helped to hire and train six Rayon Computer Center staff from Ferghana oblast on general computer skills, programming, and trouble-shooting, as well as on specific skills necessary to maintain and operate the newly-introduced health information system and databases
- ? Trained computer specialists from Rayon Computer Centers, head doctors, and Financial Managers from all six rayons in completing patient encounter and referral forms
- ? Signed a Memorandum of Understanding with the Uzbekistan National Medical Information Center to share information and reference materials related to medical/clinical information

Now that the population data entry is nearing completion, ZdravReform has started to introduce the clinical information forms into the primary health care facilities and, once this becomes routine, will begin entering data into the clinical information database at the Rayon Computer Centers.

IV. Strengthening Clinical Capacity

Over the past year, ZdravReform strengthened the clinical capacity of health personnel and facilities in three ways: (1) providing on-site clinical training courses; (2) providing access to international reference materials and interaction with Western General Practitioners and family physicians; and (3) providing technical assistance in pharmaceutical policy and management.

Realizing that reform of the health care system depends on the presence of skilled personnel and hoping to complement long-term General Practice re-training efforts being undertaken by the British Know How Fund and the “Health” Project, ZdravReform has provided a series of on-site modular short courses for key health personnel in all 45 SVPs and SVA/FAP complexes in the three experimental rayons in Ferghana oblast. This included:

- ? Developing nine modular short courses based on international training materials, aimed at addressing the main causes of morbidity and mortality in Ferghana oblast: acute respiratory infection, control of diarrheal disease, anemia, hypertension, reproductive health, breastfeeding, intestinal parasites, emergency medicine/first aid, and rational prescription of drugs
- ? Arranging for review of the nine short course curricula by international experts and the scientific council of the Tashkent Institute for Advanced Medical Education for technical content and appropriateness to the rural setting in Uzbekistan
- ? Training over 80 doctors and 80 nurses in SVPs and SVA/FAP complexes in all nine courses
- ? Conducting follow-up monitoring of knowledge retention
- ? Drafting a position paper on advanced training for primary health care physicians, proposing a number of pathways to certification as family medicine specialists, both pre-service (at the

undergraduate and graduate levels) and in-service (Know How Fund ten-month course or completion of a certain number of hours of on-site short courses)

- ? Developing reference materials in Uzbek for SVPs based on internationally-accepted literature on reproductive health, anemia, diarrheal disease, breastfeeding, and hypertension

ZdravReform also provided information about Western approaches to family medicine and primary health care by:

- ? Distributing copies of our curricula on acute respiratory infection, control of diarrheal disease, breastfeeding, and reproductive health to Know How Fund General Practice trainers at the six regional medical institutes in Uzbekistan
- ? Providing a copy of *Vidal's Reference: Drugs from Russia* and *A Reference Guide for General Practitioners* in Russian to each primary health care facility in the three experimental rayons
- ? Providing copies of additional reference books in Russian for Training SVPs and medical libraries
- ? Providing 200 copies of a ZdravReform regional laboratory manual for primary health care facilities in transitional countries to the Ministry of Health and primary health care facilities in Ferghana oblast
- ? Designing a four-week study tour, organized and financed by GTD, on General Practice to the UK for nine rural physicians from experimental rayons in Ferghana oblast that included a series of lectures and workshops, as well as a week-long "mini-residency" for Uzbek physicians in rural primary health care clinics outside of London
- ? Facilitating participation of physicians from primary health care facilities in a one-day symposium called "A Day in the Life of an American Family Physician" put on as part of a humanitarian aid mission coordinated by "Heart-to-Heart" in Tashkent
- ? Collaborated with the USAID-funded International Executive Service Corps (IESC) to invite two experienced U.S. health professionals to work with head doctors, senior nurses, and financial managers during two seminars to: discuss how both roles and responsibilities of nurses and health managers must be expanded to improve primary health care service delivery; suggest appropriate quality improvement mechanisms to increase the quality of care provided at these primary health care facilities; and discuss how American practices and experiences can be adapted to the rural setting in Uzbekistan.

Clinical Training Improves Screening for Hypertension

In an attempt to measure the effects of our short-course clinical training, ZdravReform collected data from hypertension registries in facilities in experimental and control rayons in Ferghana oblast to see if the rate of patients registered for hypertension was higher in experimental than in control rayons due to more physicians measuring blood pressure on all adult patients, a key message of recent ZdravReform clinical training on hypertension and cardiovascular disease.

Preliminary findings suggest that the odds of being registered with hypertension were 1.7 times greater in the experimental rayon primary health care facilities than the control rayon facilities. Furthermore, a greater proportion of the cases were registered more recently in experimental rayons, suggesting that increased registration was a direct result of recent training efforts. Of all cases registered with hypertension in the past two years 76% were in the experimental rayon facilities, whereas in cases of hypertension that have been registered for more than two years, only 46% were registered in the experimental rayon facilities.

In the area of pharmaceutical policy and management, ZdravReform has:

- ? Funded printing of the first edition of the National Essential Drug List
- ? Informally assessed drug supply and availability in Uzbekistan and in rural primary health care facilities in Ferghana oblast
- ? Trained SVP and SVA/FAP physicians on rational drug prescription, drug interaction, and rational drug administration to special groups (children, pregnant women, etc.) and for specific diseases (hypertension, diabetes, goiter, and anemia)
- ? Changed prescribing practices through clinical training for hypertension, encouraging rural physicians to prescribe two-three internationally-accepted medicines to manage hypertension instead of the 10-12 medicines previously used
- ? Provided technical assistance to establish a drug list (“formulary”) for the Ferghana Oblast Hospital, resulting in a list of 266 drugs that, if properly implemented, will reduce excess expenditures on less effective or more costly drugs and allow local doctors to become more familiar with, and more competent in using and prescribing, selected drugs

V. Community Involvement: Small Grants and Health Promotion

ZdravReform initiated health promotion and marketing activities aimed at involving the population in health reform efforts and in taking more responsibility for their own health. Activities included: (1) creating and strengthening the role of non-governmental organizations (NGOs) in community health through a small grants program; and (2) implementing broad health promotion and marketing activities.

The NGO grants program was designed to help address health problems specific to rural populations in Ferghana oblast, to strengthen the links between the population and health care facilities, and to strengthen rural civil society. To date, ZdravReform provided technical assistance to NGOs, primary health care facility doctors, and community-based organizations like mahallas by:

- ? Conducting community needs assessments with health personnel, mahalla representatives, and NGOs, concluding that often the most pressing health need in rural communities was the need for clean water
- ? Hosting a round table to identify ways that health personnel, mahallas, and NGOs could work together to improve reproductive health in their communities; the roundtable resulted in a number of grant applications be written and submitted for funding
- ? Providing grants aimed at improving public health, totaling approximately \$30,000 to nine NGOs and Associations in Ferghana oblast focusing on reproductive health, family planning, sexually transmitted diseases, acute respiratory infection, goiter, hygiene, and diabetes, resulting in over 290 seminars with over 6,183 participants
- ? Providing direct material assistance of water pipes and pumps to seven communities providing clean water to over 25,000 people in return for mahalla agreements to finance labor costs for installation and maintenance and development of related health promotion materials on hygiene
- ? Monitoring small grant activities and progress of community water projects and providing ongoing technical support by advising grantees on ways to improve their training modules, curricula, evaluation questionnaires, and reporting
- ? Providing assistance to the SVP Association by: sending the head of the Association to Bishkek to share experiences with the National Family Group Practice Association in Kyrgyzstan; providing training, with assistance from Counterpart Consortium, to the

Ferghana oblast SVP Association in Association Development; and supporting processes to collect applications from potential members and prepare the necessary registration forms to register as an NGO with the Justice Department

- ? Developing a means to evaluate the overall impact of the small grants program by investigating how the grants program has influenced the interaction between the population, SVP staff, and mahalla committee representatives

Health promotion and marketing activities were also initiated over the past year. In June 1999, ZdravReform developed a marketing plan for Uzbekistan based on the project's regional health marketing strategy. The plan included health promotion activities designed to increase the patient's responsibility for his own health and to advocate the use of family-centered, low-cost primary health care facilities. As part of the regional strategy to increase health worker knowledge and support for reforms, ZdravReform in Uzbekistan has translated into Uzbek and distributed several issues of the ZdravReform regional informational bulletin "Time to be Healthy." These bulletins contained key information and lessons learned from the reform process in Kazakhstan, Kyrgyzstan, and Uzbekistan and were widely distributed to health facilities in Ferghana oblast.

In October and November 1999, in coordination with the National Center for Health, ZdravReform translated into Uzbek and adapted WHO/UNICEF brochures on prevention and home treatment of acute respiratory infection and diarrheal diseases, as well as a brochure called Keeping Children Healthy that provides information to mothers about a number of childhood illnesses and recommends proper immunization and nutrition. Brochures were printed in December and distributed in early 2000.

In spring 2000, ZdravReform developed a detailed work plan for a multi-media information, education, and communication (IEC) campaign on control of diarrheal disease in collaboration with regional health marketing experts. The campaign was designed to provide key messages on prevention and treatment of diarrheal disease to mothers and health workers using a variety of formats, including written materials, use of mass media, lectures, and community peer education. ZdravReform, in coordination with the Republican Health Center, UNICEF, and other donors, developed and adapted materials such as posters, brochures, and television and radio spots in Uzbek on basic hygiene, breastfeeding to prevent diarrhea, and symptoms and home treatment of diarrhea targeted to mothers. A diagnosis and treatment chart on diarrhea based on WHO materials also was developed and translated into Uzbek for primary health care workers.

Community Knowledge on Diarrhea Prevention Increased Due to IEC Campaign

Throughout April 2000, USAID/ZdravReform conducted a multi-media information, education, and communications (IEC) campaign targeted at increasing community knowledge about diarrhea prevention, especially among mothers. The campaign included radio spots, television announcements, and newspaper articles, posters, brochures, and lectures by doctors and mahalla representatives.

Results of the month-long campaign were dramatic according to surveys conducted among 240 women before and after the campaign. Eight percent more women knew the causes of diarrhea and how to prevent it. Eight percent more women could name two symptoms of diarrhea, while 15% more could name three or more symptoms. Twelve percent more women reported that they would seek medical care if there were no improvements in the health of their child after three days. Finally, 21% more women surveyed said they would give more liquids and 42% more women said they would feed the child more to avoid dehydration and weight loss while the child had diarrhea.

The campaign was kicked off April 1, 2000 so that messages would reach mothers before summer when the prevalence of diarrheal disease increases in Ferghana. Surveys of mothers to measure

change in knowledge due to the April campaign were implemented with the help of Peace Corps Health Volunteers in late March and again in mid-May. The survey was designed to test mothers' knowledge on causes, prevention, and treatment of diarrheal diseases. Preliminary findings suggest an increase in awareness and knowledge due to the month-long campaign.

Annex A: Summary of the Central Asian Health Reform Model

Development of a health reform model is a process requiring identification of health sector problems, determination of solutions, and development of a framework or model that allows the solutions to be implemented in a cohesive and integrated manner. In response to the peculiarities of the Soviet health system legacy, the USAID-funded ZdravReform Project being implemented by Abt Associates Inc. developed a regional health reform model for implementation in Central Asia. There are four main components of the Central Asian health reform model: 1) Restructuring the health delivery system and strengthening primary health care; 2) Involving communities and the population in health issues and health reform efforts; 3) Implementing effective health care financing by introducing new provider payment systems; and 4) Introducing management information systems. Improving the legal and policy framework for health reform and increasing public awareness of reform efforts are elements of each of these components.

Restructuring the Health Delivery System and Strengthening Primary Health Care

One of the most profound inefficiencies in the health care system is the imbalance between the hospital and primary health care sectors. Hospitals consume more than 70 percent of the health care budget. The health delivery system inherited from the former Soviet Union can be likened to an inverted pyramid. The hospital sector at the top of the pyramid is overdeveloped and the primary health care sector which should serve as the broad base of the pyramid is underdeveloped, under-financed, and under-utilized. Solving this problem requires complete restructuring and strengthening of the primary health care sector through the creation of new primary health care practices.

There are also clinical obstacles to the development of the primary health care sector. Primary health care has been inadequately provided in the past through catchment area physicians with incentives to refer quickly to specialists. Training of primary health care physicians, by Western standards, is inadequate, and thus conditions that should be effectively treated in the primary health care sector are treated in the hospital or by specialists at polyclinics. Solving this problem requires introduction of general or family practice and upgrading of clinical skills. Clinical areas, such as reproductive health and infectious diseases, should be incorporated into primary health care. In addition, extensive vertical health programs for tuberculosis, sexually-transmitted infections, psychiatry, and oncology that were maintained by the Soviet system also should eventually be integrated into primary health care.

Population Involvement

In the Soviet system, the population was not involved in decisions about their health care. They had limited rights as well as limited responsibilities. They were unable to choose their primary health care provider and their health care provider did not provide them with information about their condition. Provider payment systems funded the infrastructure of the health sector not the health services received by the population, and as the state provided everything, people did not take responsibility for their own health.

The rationale for increasing population involvement in decisions about their health care consists of four major reasons: 1) Introduction of consumer choice is closely tied to the reorganization of the primary health care system; 2) Informed consumers are more likely to become active consumers who hold providers accountable and thus play a role in improving the quality and

efficiency of health care; 3) Increased power in decision-making about health care can contribute to the desire for more democratic participation in other parts of society; and, 4) as government resources for health care shrink, the population needs to take more responsibility for their own health status and engage in healthier lifestyles.

Addressing these issues requires redefinition of both population rights and responsibilities. The population should be given the right of free choice of primary health care practice through an open enrollment process, as well as rights to obtain information about their health condition and to be covered under various health insurance systems. Population responsibilities must change as well, as consumers being to inform themselves about their health status and to engage in healthier lifestyles by improving their diet, stopping smoking, or reducing alcohol intake.

Health Financing and Provider Payment Systems

The legacy of the Soviet system and the turbulent transition to a market-based economy has had dramatic consequences for the health sector in Central Asia. Resources available to maintain the health care system have fallen drastically, with health care expenditures as a percentage of GDP declining from approximately 6 percent to 3 percent since 1991. In addition, GDP fell around 50 percent resulting in a significant reduction of real per capita health expenditures.

The declining health sector resource base cannot sustain the current service infrastructure. The overly specialized system contains excess capacity and high fixed costs. Because facilities have historically received their funding based on a combination of capacity and utilization rates, incentives for providers have been to maintain large, inefficient physical structures and excessive medical staff.

The allocation of health resources in Central Asia has followed the traditional Soviet chapter budgeting process, allocating health funds across facilities by input measures, such as the number of beds, rather than by the quantity and quality of services delivered. Budgets were guaranteed and providers did not have to compete to attract the population by providing lower cost, higher quality health services. The budgets were disbursed by budget chapters according to strict norms. Since budgets were required to be spent according to chapter allocations, facilities could not use their resources in the most cost-effective manner.

Changes in the way health providers are paid is needed to change the underlying incentives to introduce competition, encourage increased efficiency, and allow hospitals greater autonomy to allocate resources.

Management Information Systems

In the former Soviet Union, the Ministry of Health collected enormous amounts of information on health sector budgets, service utilization, and health status indicators. The data, however, were not compiled in a way that facilitated analysis, and it was difficult to link costs with utilization or health outcomes.

To survive in the ongoing transition to a market economy, the inpatient and outpatient sectors must both function more as businesses. Hospitals must understand the costs of providing their services and develop plans to reduce costs, increase revenues, and produce an optimal mix of services. Primary health care providers must be concerned about the health of their practices as well as that of their patients, and they must market themselves to the users and purchasers of health care.

At the health purchaser level, health management information systems are required to support the design, implementation, and evaluation of new provider payment systems and quality assurance systems. At the health provider level, new management information systems are needed to provide health facility managers with tools to adapt to the new environment, and support better decision-making and allocation of resources. New management techniques need to be introduced and new health management careers established, for example, practice managers for primary health care entities.