



*ZdravReform/ЗдравРеформа*

## **Kazakhstan Health Reform Overview**

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## **Health Reform in Kazakhstan: Overview and Next Steps**

### **Introduction**

Significant progress has been made in health reform in Kazakhstan, even given the lack of a stable policy framework caused by frequent changes in the government, both within and outside of the health sector. One of the most dramatic changes was the decision to move the capital of the Republic from Almaty to Astana. The move of the capital created confusion in most government departments, as many long serving officials left the government. The Ministry of Health was abolished and subsumed into a supra-ministry for health, education, and sport in 1997, and became the Committee of Health within the Ministry of Health, Education and Sport. At the regional level, oblasts were merged, which created administrative confusion. Oblast akims (governors) have changed frequently, leading to changes in personnel in all of the key oblast departments, including health. Given this constant change in government structure, the health reform process has had to adapt to a continually changing environment.

In Kazakhstan the ZdravReform Program has used the strategy of a rolling design, which allows the health reform model to be implemented using technical assistance strategies that are adapted to the rapidly changing policy environment. ZdravReform's initial focus was to establish regional health reform demonstration sites, which would develop working models for health reform. The experience of implementing reforms created experience, which was used to influence national health policy. In the demonstration sites, primary care restructuring was accomplished in both urban and rural areas. New provider payment systems were implemented, which included new financial and clinical information systems. After the demonstrations were functioning, the program moved to the national level.

Progress was made to strengthen the national legal basis for reforms, and to put a process in place for expanding implementation of certain elements of the reform model throughout the country. However, recent changes at the national level such as the cancellation of the mandatory health insurance system, and the continued decentralization of the health care system have made national roll-out difficult. It became clear that although it is important to strengthen the national legal support for reforms and build capacity in the national Committee on Health for national implementation, much technical assistance is still needed at the oblast level, and in many ways it was premature to roll out reforms nationwide.

Collaboration on the new World Bank health sector loan in Kazakhstan provides an excellent opportunity for USAID and the ZdravReform Program to deepen and widen the oblast level demonstrations, and to continue to build a cadre of professionals with health reform experience that can eventually contribute to national level roll-out.

### **History**

The origin of the health reform program in Kazakhstan stemmed from the need to solve problems in health care financing and service delivery that are similar to all countries of

the former Soviet Union. The health sector in Kazakhstan was well developed and emphasized universal access to a basic level of health care. There was also substantial investment in curative medicine, prevention, and water and sanitation, which were all beneficial to the general health of the population. The system was developed, however, with little attention to efficiency. One of the greatest inefficiencies in all former Soviet health care systems is the imbalance between hospital and outpatient, particularly primary care. In Kazakhstan, hospitals received more than 75 percent of government health care resources in 1996. This imbalance reduced the capacity of the primary care sector to provide adequate services to the population, causing primary care physicians to refer simple cases to specialists and hospitals, or for patients to bypass primary care entirely and refer themselves directly to hospitals.

Over the past ten years, the inefficiency of the system has been exposed by the severe socioeconomic and environmental problems that have been born out of the legacy of the Soviet system and the turbulent transition to a market-based economy. Resources available for health care in Kazakhstan have declined steadily since the 1980s, with health care expenditures as a percentage of gross domestic product (GDP) declining from 6 percent in the 1980s to less than 3 percent in 1996. In addition, GDP continued to fall over that period, resulting in a significant reduction in real per capita health expenditure. The health care system is in crisis, suffering from chronic underfinancing and inefficient use of the limited resources that are available. The consequences for the population's health have been significant. Life expectancy has declined from 63.9 years for men in 1989 to 59.0 in 1997, and from 73.1 to 70.2 for women over the same period.

The Government of Kazakhstan has long recognized the need for health care reform. The earliest reform activities began before independence from the Soviet Union, with the establishment of five health reform demonstration sites in Kazakhstan under the New Economic Mechanisms (NEM) in 1989. Although the NEM demonstration sites in Kazakhstan were cancelled in 1990, some general principles of reform had already taken root. In 1992, the new government of independent Kazakhstan established three oblasts as new health sector demonstration sites (Zhezkazgan, South Kyrgyzstan, and Kokchetau). Under the demonstration program, one area of the former Zhezkazgan oblast 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 with a decree in June 1995, which guaranteed health insurance for all citizens of Kazakhstan. From the perspective of health policymakers in Kazakhstan, the main purpose behind health insurance was to create a stable source of additional funding in the health sector. The ZdravReform program's perspective was that health insurance created an opportunity to introduce more comprehensive reforms to improve the performance of the health care system. With ZdravReform assistance, health insurance was used as a mechanism to introduce new provider payment methods, promote the development of health information systems and modern management techniques, and encourage the development of a strong system of primary care. Because of the close connection in Kazakhstan between the new health insurance system and national health strategies for health reform, the ZdravReform

Program in Kazakhstan has in many ways been linked to the process of development of the health insurance system.

Before the adoption of health insurance, ZdravReform argued for a single payer system, where the insurance fund would become the purchaser of health care. Kazakhstan ultimately opted to adopt the Russian model of health insurance, which created overlapping financial responsibilities for the Ministry of Health and the Mandatory Health Insurance (MHI) Fund. The MHI Fund, however, became the major payer for health services. The structure of health insurance in Kazakhstan made conflict inevitable between the MHI fund and the Committee of Health, which eventually led to the re-incorporation of health insurance into the Ministry of Health, Education and Sport in late 1998. Although this has created a single-payer system, one of the unintended consequences was to lose the flexibility for introducing new provider payment systems, because of tight regulatory control by the Ministry of Finance on how public funds are allocated. Therefore, Kazakhstan has returned full-circle to many of the financing mechanisms inherited from its Soviet past.

### **The ZdravReform Program**

In Kazakhstan, the ZdravReform Program initially concentrated its technical assistance in the South Kazakhstan Oblast Intensive Demonstration Site. This site was chosen to initiate project activities based on the Ministry of Health's designation of this oblast as a health reform demonstration site in 1992. Although this oblast had a history of experimentation with health reforms, there were still political obstacles to implementing a comprehensive health reform program. Early in 1996, therefore, ZdravReform slightly modified the implementation strategy in Kazakhstan from the Intensive Demonstration Site approach to a strategy in which the program provided technical assistance from the Regional Office to selected oblasts that had already demonstrated a real commitment to undertake health reforms. ZdravReform began to shift resources from South Kazakhstan Oblast to additional locations, or Comprehensive Demonstration Sites, just as the Government of Kazakhstan officially established pilot oblasts to test insurance and payment reforms.

In 1995, when the Government of Kazakhstan extended the small-scale health insurance experiment in a region of Zhezkazgan to the entire oblast, Zhezkazgan became the first oblast in Kazakhstan to finance health facilities through mandatory health insurance. The Oblast Mandatory Health Insurance (MHI) Fund began financing health facilities in July 1995, and an extensive health care financing and service delivery reform effort was underway.

In June 1995, local officials in Zhezkazgan invited ZdravReform to observe the reform process and provide recommendations for technical assistance. ZdravReform began working with the Oblast Health Department and MHI Fund to refine and expand the progress in new provider payment methods, service delivery restructuring, and privatization, and create a truly integrated package of health reforms.

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 to advance the reform program that had recently been approved by the Oblast Administration. When the Federal MHI Fund granted Semipalatinsk status as a pilot oblast in April 1996, ZdravReform developed a plan for comprehensive 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 environment in these oblasts was highly conducive to reform, and the health sector labor force was 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 care reforms were the centerpiece of the reform package. Primary care restructuring was carried out, and clinical strengthening of the new primary care practices was begun. At the same time, new economic incentives were created for health providers with the implementation of per capita payment for primary 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 care practitioners from the new practices organized themselves into non-governmental associations, which were active in policy dialogue and instrumental in helping to carve out the new role for primary care in the system.

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 visible leader in health reform in Kazakhstan. In Semipalatinsk, the rural reforms were weakened by the oblast merger, and the demonstration site has been reduced to Semipalatinsk City and two surrounding rayons. The upcoming World Bank health sector loan, however, which was initially placed in Semipalatinsk Oblast because of the health reform progress already achieved there, 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 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.

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 has been 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. This 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.

### **Current Institutional Structure**

The national policy environment and the institutional structure in the health sector in Kazakhstan continue to change rapidly, and it is still not entirely clear where the system will settle. Several policy trends have emerged, however, that indicate that Kazakhstan is opting away from a national health care system and toward more regional variation in financing and service delivery policies. The level of decentralization and regional autonomy, which have always been strong in Kazakhstan, have been further entrenched by new legislation passed since the beginning of 1999.

The most significant change in national health policy during this period in Kazakhstan was the termination of national health insurance and the closure of the Mandatory Health Insurance (MHI) Fund at the end of December 1998. Although the MHI Fund was initially replaced by an alternative national level health financing institution, the Center for Health Purchasing, all government health care financing has effectively been returned to the general budget, which is administered at the local level.

A second change in national health care financing policy in Kazakhstan in the past six months is the expansion of the role of "GosZakaz," a government competitive procurement

mechanism that was previously used only in very limited ways for health care. *GosZakaz* 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. Since January 1999, *GosZakaz* contracts have replaced Mandatory Health Insurance contracts as the main financing mechanism for the vast majority of health care providers in Kazakhstan.

The form of *GosZakaz* contracts, the tendering process and the institution administering the *GosZakaz* all vary by oblast, and even by rayon and city within oblasts. In some areas *GosZakaz* is administered by the Center for Health Purchasing, while in others the akims themselves administer the process, bypassing the CHP. Most oblast administrations have not carried out actual tenders, but have signed contracts with all health care providers, both public and private, that currently receive government financing. In many areas, the contracts specify a price per service and maximum volume of services, which are unique to each health care facility. The policy of locking providers into a volume and setting each provider's price based on historical costs directly contradicts the implementation of incentive-based provider payment systems.

The changes in the institutional structure in the health sector in Kazakhstan, therefore, reinforce the need for a technical assistance strategy that focuses on putting operational systems in place that can be adapted for any system that is finally chosen. The recent changes also reinforce need for a regional level focus in health reform implementation.

## **Next Steps**

Strategizing and planning next steps for technical assistance in Kazakhstan needs to take into account four parameters: Program, Opportunities for collaboration, Government level, and Geography.

The first parameter, program, refers to the four components of the health reform model: 1) Health delivery system restructuring and strengthening primary health care; 2) Population involvement; 3) Health financing and provider payment systems; and 4) Management information systems.

As discussed throughout this paper, Kazakhstan has experienced radical changes in government structure over the last five years, including moving the capital, merging oblasts, merging ministries, and decentralizing authority from the national to the regional level. While these changes in government structure have disrupted health reform at times and forced ZdravReform to adapt its program strategies, the relevance of the health reform model and program activities has never been an issue. Quite the opposite is true, as the existence of a relevant and consistent health reform model has mitigated the uncertainty and allowed health reform to continue to move forward in Kazakhstan. Therefore, it is important to retain the health reform model and continue to implement the four components at all levels of government and in all geographic areas.

The second parameter, opportunities for collaboration, refers largely to the collaboration with the World Bank-financed health sector project. Over time, USAID and the ZdravReform Program have built an extremely productive relationship with the World Bank to implement health reform in Kazakhstan, as well as throughout Central Asia. At times during the design phase, building this collaboration was not easy, particularly because the oblast mergers created a lot of difficult politics. However, after the design phase was completed, a co-financing arrangement was agreed to between USAID and the World Bank, and the project became effective in August, 1999. Following significant start-up costs, the investment in collaboration is beginning to pay dividends.

Over the last year, ZdravReform has provided “bridge” technical assistance for the purpose of facilitating the acceleration of project start-up. ZdravReform will continue to provide technical assistance to East Kazakhstan Oblast and facilitate initial activities in Almaty Oblast until June 2000. However, delays in implementation of the World Bank project have pushed the time schedule back by about a year, and it should be decided whether providing technical assistance to implement health reforms in the World Bank Project Oblasts of East Kazakhstan and Almaty will continue.

The third parameter, government level, refers to whether reforms are targeted at the national level, oblast level or both. This issue was discussed in detail earlier in this paper, with the conclusion that both national and oblast levels need to be targeted. The national level in Kazakhstan does not have the authority or capability to implement national health reform right now. However, it has a vital role to play in the development of a policy framework for health reform and in the development of broad regulations and rules, which are implemented at the oblast level. For example, the national level has and should continue to develop a broad policy framework and some rules for hospital payment while the oblasts retain flexibility in actual implementation. In the future, this may be the optimal relationship between national and oblast levels – broad health policy and parameters set at the national level, with oblast level implementation.

Health reform implementation must continue to be targeted at the oblast level. It is important to continue to strengthen the leading health reform sites, as well as begin the process of extending health reforms to other oblasts. In essence, this describes the collaboration with the World Bank, as the intent of the project is to strengthen the health reforms in Semipalatinsk region and then extend them to East Kazakhstan.

The last parameter, geography, determines which specific geographic areas to focus health reform. It is important to continue to strengthen Zhezkazgan, while focusing more on the extension of reforms to Karaganda. Karaganda is the leader in health reform in Kazakhstan, and the lack of a strong national level enhances their leadership role as other oblasts look to Karaganda. As discussed, the World Bank Oblasts of East Kazakhstan (including Semipalatinsk) and Almaty are also priorities.

It is important to begin work in Astana City, not only because of the national level connection. Astana does not have the problem plaguing Almaty City and other oblast capital cities. In Almaty City there are two health delivery systems – republican level and



city level. One of the biggest challenges in the health reform process is to rationalize facilities and funds flow across these two delivery systems, which are owned, operated, and funded by different government units. This problem does not exist in Astana, making it potentially a highly favorable health reform site.

The target of opportunity model should continue meaning that oblasts that meet pre-conditions for health reform should be supported. For example, Pavlodar Oblast has met some of the pre-conditions, such as demonstrated political will and initiation of some parts of the reform model. Finally, if health reforms are extended to other oblasts, a viable strategy may be to focus on oblasts with Medical Academies who can drive the reforms – Aktubyunsk in the west, and South Kazakhstan in the south as health reforms are being implemented in the north and east of Kazakhstan.