



ZdravReform/ЗдравРеформ

Summary of Semipalatinsk

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SUMMARY OF SEMIPALATINSK HEALTH REFORM ACCOMPLISHMENTS

1. Background

A comprehensive health reform program has been implemented in the former Semipalatinsk Oblast since 1995. The health reform program is integrated, with restructuring and new financing mechanisms implemented at all levels of the delivery system. In addition, the reforms were implemented at the oblast level, covering nearly all health facilities in the former Semipalatinsk Oblast. The health reform model adopted in Semipalatinsk has been evaluated and supported by the Ministry of Health and international experts. A national level document has been signed by the Minister of Health, the General Director of the Mandatory Health Insurance Fund, and the Akim of East Kazakhstan Oblast for the continuation and expansion of the reform program.

The World Bank-financed project in the Western Region of East Kazakhstan Oblast (the former Semipalatinsk Oblast), therefore, will be implemented starting from a more advanced stage than in other sites included in the project, and the pace of the project will be accelerated. The project should move Semipalatinsk on a fast track, then bring the rest of East Kazakhstan Oblast to the level of Semipalatinsk. By the end of the project, the new finance and service delivery systems will be fully operational in the entire oblast. This strategy of establishing a “lead health reform site” under the World Bank-financed project has been successfully adopted in both Kyrgyzstan and Uzbekistan.

The remainder of this section summarizes the accomplishments and current status of the Semipalatinsk health reform program.

2. Macrofinancing and Benefits Package

In 1996, when the MHI Fund was established in Kazakhstan, Semipalatinsk Oblast began a series of financing reforms that pay health facilities according to activity and the services they produce, rather than a guaranteed fixed budget based on capacity. The financing reforms, combined with increased management autonomy, give health facilities the incentive to manage their resources carefully to achieve the greatest health benefit for their expenditures. Two important steps were taken by the local government of Semipalatinsk to support the health reforms: the creation of a unified health budget at the oblast level (vertical pooling of funds), and channeling nearly all health care funds through the MHI Fund (horizontal pooling of funds).

Immediately after the national health insurance system was established in Kazakhstan, the Semipalatinsk MHI Fund and the Oblast Health Department made a joint recommendation to the Oblast Akim to divide financing responsibility between the Guaranteed and Basic benefits packages so as to provide the optimal economic incentives to health facilities. The financing responsibility was divided according to health facilities rather than by type of service, so each health facility in the Oblast would receive its financing from only one source. The Oblast Health Department financed the dispensaries, ambulance services, the blood bank, SES and other high-cost specialty facilities, while the MHI Fund financed the remainder of the

health facilities in the system. As a result, nearly 80 percent of government health care funding in the Oblast was channeled through the MHI Fund. This strategy reduced administrative costs, and sent clear price signals to the health facilities so they could begin to adapt their service delivery to the payment system they faced.

Vertical pooling of funds was achieved by the creation of a unified health care budget in 1997. Rayon and city health budgets were pooled at the Oblast level. This allowed health care funds to be reallocated back to cities and rayons through new payment systems, rather than being determined by the political and economic power of the local governments.

This vertical and horizontal pooling of health funds allowed the allocation of health resources to be disengaged from historical budgeting patterns and to be allocated according to activity and the health needs of the population. This important political step in support of health reform has been partially reversed since the merger of Semipalatinsk with East Kazakhstan Oblast, but should again be a goal for all of East Kazakhstan Oblast under the World Bank-financed project.

3. Strengthening Primary Care

3.1 Structure of Rural Primary Care

In the rayons of the former Semipalatinsk Oblast, all SVAs and FAPs, with the exception of those in rayon settlement areas, have been combined into SVA-FAP complexes, which are independent from the Central Rayon Hospitals. There are currently 129 SVA-FAP complexes in the rayons that constitute the former Semipalatinsk Oblast. The SVA-FAP complexes are juridical entities with their own bank accounts, and they receive their financing directly rather than through the Central Rayon Hospitals. All SVA-FAP complexes are currently financed entirely by the Semipalatinsk Regional MHI Fund.

Since 1995, all SVA-FAP complexes have been converted to “property rent” status, which is a form of governmental ownership with management autonomy. The contract for property rent transfers the right to occupy, use and manage the health facility to the “renter” (Head Doctor) for a defined period of time. The rights of ownership remain with the Territorial Government Property Committee. The property rent contract also determines the amount of rent to be paid for the facility, and defines the criteria for the volume and quality of medical services to be provided by the renter.

It was intended that the managers of the SVA-FAP complexes would eventually pay rent to Territorial Government Property Committee for the facilities, with the ultimate goal being full privatization and transfer of assets to the private owners. The Semipalatinsk Oblast Health Department granted the facilities one year of rent relief to give the new managers the opportunity to adapt to the new system, and for the MHI Fund to develop a financing system that accounts for the rent expenditures. The Oblast Health Department also worked with the SVA-FAP complexes to determine the most advantageous form of registering the new independent entities with regard to tax burden.

Under the property rent status, the SVA-FAP complexes have gained management autonomy, meaning that they have the authority to allocate their financing across budget chapters and to determine their staffing patterns and to make other resource allocation

decisions. The SVA-FAP complexes, however, are still required to pay health care workers according to the national wage schedule. This constraint prevents the facilities from fully optimizing their resources by, for example, paying employees according to an incentive-based system.

The former Semipalatinsk Oblast Health Department strongly encouraged the newly independent facilities to carefully plan the use of their resources and begin to operate more like businesses. According to banking laws, all juridical entities with bank accounts must employ an accountant. Therefore, all SVA-FAP complexes now either employ an accountant or pay for the services of the Central Rayon Hospital accountant. In addition, as part of the transition to non-governmental ownership, the Oblast Health Department required the SVA-FAP complexes to submit business plans, which then became a routine reporting requirement.

Currently, all SVA-FAP complexes remain under property rent status. The strategy of eventually privatizing SVA-FAP complexes, however, was abandoned after Semipalatinsk was merged with East Kazakhstan Oblast.

3.2. Capitated Payment for Rural Primary Care

3.2.1 Development of Payment System

In order to ensure an adequate and stable flow of financing to the rural primary care sector, the MHI Fund decided jointly with the Oblast Health Department to implement a capitated payment system for rural primary care services. Beginning in September 1996, all SVA-FAP complexes are paid a monthly per capita rate for each individual enrolled in the facility. The capitated rate covers only primary care services, and all referrals are financed independently by other payment systems.

The Semipalatinsk MHI Fund developed capitation rates by aggregating the 1997 budgets for all independent SVA-FAP complexes in each rayon, and dividing the total budget by the aggregate population enrolled in these facilities. This formula produced budget neutral rayon average capitation rates, with all SVA-FAP complexes in one rayon receiving a single capitated rate. A SVA-FAP complex's monthly payment from the MHI Fund is the rayon average capitation rate multiplied by the number of individuals enrolled in the facility.

The variation in rates across rayons is based on historical resource allocation patterns, which are determined by regional availability of budget funds, and are largely independent of variations in the primary health care needs of the population. This approach was adopted for the short term in order to begin the process of improving the equity of resource allocation across primary care facilities. The first stage of the payment system was politically feasible because it did not change any facility's budget significantly, and it did not force inter-rayon transfer of resources. It was intended that the capitation rate would move gradually to an oblast level average rate to give facilities time to adjust to new levels of financing.

3.2.2 Quality Standards and Performance Monitoring

Although the SVA-FAP complexes have been granted increased autonomy and independence, the Oblast Health Department and MHI Fund retain control over the facilities through the medical statistical reporting system, financial contracts and reporting, and the licensing and accreditation process. For example, in February 1997, the Semipalatinsk Oblast

Health Department revoked the license and government contract of one SVA-FAP complex and one family clinic because they did not meet the Department's quality standards. Without government contracts, these facilities are no longer eligible to receive government financing, neither from the budget nor from the MHI Fund.

The innovation in Semipalatinsk, however, is that although the government retains control over the outcomes of the primary health care system, they have reduced their control of the process by which health facilities achieve those outcomes. SVA-FAP complexes are responsible for maintaining the health of their populations, as measured by indicators of quality and health outcomes developed by the Oblast Health Department and MHI Fund. The facilities have the freedom, however, to allocate their resources in the best way to achieve high quality of care and improved health outcomes according to their particular circumstances and the health needs of their populations.

To ensure that the capitated payment system and increased financial autonomy of primary care facilities did not negatively affect quality of care, the Oblast Health Department and MHI Fund developed a bonus/penalty system to link the financing of SVA-FAP complexes to their performance. A set of ten indicators of quality of care was developed, including, for example, infant and maternal mortality, infant deaths in the home, inappropriate hospitalization, and justified consumer complaints. The performance of each SVA-FAP complex is evaluated against these indicators on a quarterly basis by the MHI Fund, and the capitated payment is adjusted upward or downward according to performance. The bonus system has been implemented first as a "paper" system to give facilities the opportunity to see how their financing would have been affected by their performance during the last quarter. Full implementation of the system will be supported by a grant from the Soros Foundation to finance the bonus pool for the first year of implementation.

3.2.3 Enrollment Database

To support the capitated payment system, four rayons completed an enrollment campaign, encouraging each family in the catchment area to come to the facility and fill out an enrollment card. This information has been entered into a population database at the Semipalatinsk MHI Fund. The official catchment areas are used as enrollment bases for the remaining 11 rayons that did not complete the enrollment campaign.

3.2.4 Capitated Rate Adjustment

The Semipalatinsk MHI Fund is currently moving to the next stage of refinement of the capitated payment system in order to disengage facility payments from historical resource allocation patterns, and to more adequately capture differences in health care needs across population groups. To accomplish these goals, the MHI Fund will gradually move toward a regional average capitation rate for the entire portion of the former Semipalatinsk Oblast financed by the Semipalatinsk MHI Fund, and apply coefficients that adjust the capitation rate for cost variations associated with the health care needs of different population groups.

With assistance from the USAID ZdravReform Program, the Semipalatinsk MHI Fund recently completed a study of rural primary care utilization to support the development of age, sex and population density adjusters for the capitated rates. Data were collected on each visit in five SVA-FAP complexes for the period of one month, with a total of 2,566 visits. Data were collected on patient characteristics, diagnosis, all procedures performed,

pharmaceuticals provided and prescribed, referrals, and distance traveled of both the patient and the health facility personnel.

Cost accounting data were used to determine the average cost per procedure for a list, developed in conjunction with SVA physicians, of 21 primary care services. The utilization data were combined with the cost data to determine the relative cost, based on utilization, of caring for different population groups. A sample of results from the survey are presented in Annex 3.1. The results were presented at a workshop attended by physicians and representatives of the Health Department and MHI Fund, and a consensus was reached on how to use the cost variations related to utilization to construct adjustment coefficients for the capitated rate.

The Semipalatinsk Regional MHI Fund plans to implement the new risk-adjusted capitated payment system during the second quarter of 1998. The new payment system, however, will only achieve its intended goal, linking primary care payment to the health care needs of the population, if the capitated rate is based on a regional rather than rayon-level average rate. Because East Kazakhstan Oblast has returned to rayon and city level health care budgeting, the Semipalatinsk MHI Fund is unable to implement a regional capitated rate.

3.3 Urban Primary Care

In the urban areas, the Oblast Health Department began reorganizing polyclinics to create primary care “micropolyclinics” and family clinics that are juridical entities, administratively and financially separate from specialty-oriented polyclinics and hospitals. Micropolyclinics are formed by keeping the primary care department physically located in the polyclinic, but establishing the primary care department as an independent juridical entity. Family clinics are located outside of polyclinics, in former women’s consultation centers, apartments or other buildings in the community. Micropolyclinics and family clinics have mixed (adult, pediatric and women’s consultation) catchment areas, so they can provide family-oriented, integrated health care with an emphasis on primary care and preventive services.

Ten micropolyclinics and family clinics have been established in Semipalatinsk City since 1995. As in the rural primary care sector, urban micropolyclinics and family clinics were granted property rent status by the Oblast Health Department. Five of these primary care entities have been fully privatized. The new independent urban primary care entities do not yet cover the entire population of Semipalatinsk City.

The urban primary care entities are paid by the Semipalatinsk Regional MHI Fund according to a per-visit payment system, with a transition to a payment system based on completed cases, according to the policy of the Republican MHI Fund. The Semipalatinsk MHI Fund has been planning to move to a capitated payment system for urban primary care entities, but the policy has been met with some resistance by the City Health Department.

The progress of urban primary care restructuring and financing reform has stalled since the Semipalatinsk Oblast Health Department was liquidated after the merger of Semipalatinsk with East Kazakhstan Oblast. The development of micropolyclinics, therefore, needs to be restarted and expanded under the World Bank-financed health reform project.

3.4 Clinical Training and Equipment

The Semipalatinsk Oblast Health Department committed resources to providing clinical training in general practice and necessary equipment to newly independent primary care facilities. The Health Department provided grants to primary care facilities to improve their equipment and to purchase postgraduate training in general medicine from the Kazakh Postgraduate Institute of Physicians and the Semipalatinsk Medical Academy. In addition, grants were awarded by USAID ZdravReform and the Soros Foundation to provide equipment and training to rural primary care physicians. Only a small percentage of primary care providers in the Semipalatinsk have been covered by these activities, however, and much support is required under the World Bank-financed project.

4. Hospital Sector

The reform of the inpatient sector in Semipalatinsk has combined some limited facility rationalization with a new, activity-based payment system. Between 1995 and 1996, more than 30 hospitals in Semipalatinsk were reorganized in some way, and hospital capacity was reduced by 4,600 beds. The reduction of hospital capacity freed resources to improve the material base, including an increase in the number of facilities, of the outpatient sector. There is some disagreement among representatives of the MHI Fund, Health Department and health facilities as to the degree of hospital rationalization that should still be accomplished.

Since April 1996, the Semipalatinsk Oblast Mandatory Health Insurance Fund has been financing inpatient care according to a hospital-specific average cost per treated case. This new payment system is a significant advance from the chapter budget system, because hospitals are paid for services provided rather than according to planned capacity. The MHIF agrees, however, that this new payment system is inadequate because it does not distinguish between types of cases, and therefore there is an incentive to under-treat costly cases or refer them to higher level facilities. In addition, paying facility-specific rates maintains the historical allocation of resources across facilities without promoting cost competition between hospitals. The Semipalatinsk MHI Fund is extremely interested in initiating the next phase of the case-based hospital payment system by moving to a classification and payment of hospital cases according to clinical statistical groups.

5. Main Conclusions

The combination of financing reforms and increased independence and autonomy for health care providers to respond to the new incentives in the system have had the overall effect of creating a sense of ownership and commitment among physicians in the former Semipalatinsk Oblast. In the period since the reform program was initiated, some improvements in health service delivery are becoming evident. These achievements have occurred even during a time of severe financial crisis in the health sector of the former Semipalatinsk Oblast. For example, one SVA in Semipalatinsk occupied a three-story building, had 27 staff positions, and used an average of 150 tons of coal in the winter. The Head Doctor of the SVA was able to make the decision to move to a smaller building, reduce the staff, and reduce the use of coal to 20 tons. Because these changes did not result in the

reduction of the SVA's financing, the facility is able to use the resources saved to provide higher quality care to its population by, for example, purchasing more medicine or initiating new programs of preventive care.

Specific conclusions and lessons learned from the Semipalatinsk reform experience can be summarized as follows:

1. The combination of increased management autonomy and new financing mechanisms that pay facilities for activity rather than capacity has the greatest impact on changing the incentives faced by health care providers, and therefore leads to the greatest improvements in efficiency and quality of care. The most important lesson from the Semipalatinsk experience is that it is management autonomy, regardless of the form of ownership, that creates the incentives for providers to improve their services. Management autonomy can be achieved in various ways, and does not require that the facility be fully privatized. If providers have the security of a long term management contract and the flexibility to make significant changes in how their resources are allocated, they will have many of the same incentives as private owners to invest in improving the facility.
2. The government can maintain much control and influence over the health care system as a purchaser and regulator of the outcomes of the health care system, even as it gives up some direct control over how services are provided. The Oblast Health Department and MHI Fund in Semipalatinsk maintain strict quality and health outcome standards, and health facilities are penalized if they do not achieve them or rewarded if they exceed them. The health facilities, however, have the independence and flexibility to make changes in their resource allocation and management in order to meet the standards by providing the highest quality care possible at the lowest cost.
3. When there are multiple sources of financing in the system, such as the MHI Fund and the government budget, optimal economic incentives can be achieved if financing responsibility is split so that each facility receives payment from only one source. If one source of financing is paying a facility according to one pricing structure, the scope for optimizing resource utilization at the facility level is greatest because facilities face clear price signals that reflect the relative costs of different services. Facilities are then able to respond by optimizing resource allocation decisions and planning for future rationalization of service delivery.
4. Semipalatinsk has succeeded by implementing its reform agenda gradually, giving facilities time to adjust to the new system. There has also been consistent education of physicians and other health care providers by the Oblast Health Department and MHI Fund throughout the reform process. Physicians are beginning to understand the purpose and the methods of the reforms, and how they can succeed in the new system. The process of changing the mentality and perspectives of physicians, however, will take time and much more education about the economic aspects of health care. Semipalatinsk has not had sufficient resources to invest in this training as much as is necessary, and therefore, many physicians are adapting very slowly to the new system. Even with insufficient formal training, however, the physicians will gradually share their experiences and learn from each other how to survive and succeed in the new environment.

**DESCRIPTION AND ASSESSMENT OF
HEALTH REFORMS IN
THE FORMER SEMIPALATINSK OBLAST**

**Prepared for the Ministry of Health of the Republic of Kazakstan
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I. BACKGROUND

In order to comply with the Government of Kazakstan's Midterm Program of 1995-1996, Semipalatinsk Oblast implemented a health reform program that included the following components: reorganization of health financing and service delivery, strengthening primary care, and privatization. The reform program in Semipalatinsk Oblast was initiated with a decision of the Oblast Maslikhat (Parliament) on December 23, 1994. The reform program had the goal of moving the health care system to a market-based system in response to the financial crisis in Semipalatinsk Oblast. The following sections of this report describe the principal components of the reform agenda, which include: reorganization of the financing and management of health care, restructuring of health care facilities, and transfer of governmental facilities to non-governmental status and private ownership. New financing mechanisms were introduced to give the appropriate economic incentives to health care providers, and increased management autonomy was given to health care providers so they can freely respond to the new incentives in the system. In addition, the primary care sector was strengthened through material support, clinical training and policies that actively shifted resources and decisionmaking authority to this sector.

II. REORGANIZATION OF HEALTH SERVICE DELIVERY

Semipalatinsk began the reform process by rationalizing the service delivery system to make more efficient use of available resources. The Oblast Health Department's strategy included reducing hospital capacity and strengthening urban and rural primary care. In a severely underfunded health care system, the most significant gains in efficiency and quality of care can be achieved by delivering a greater share of services in the primary care sector. Preventive services, early treatment and diagnosis, and management of chronic diseases can reduce the need for hospitalization, and therefore can reduce overall expenditure in the health care sector.

A. Hospital Rationalization

During the period 1995-1996, more than 30 hospitals in Semipalatinsk were reorganized, and hospital capacity was reduced by 4,600 beds. The result of the reorganization is the creation of hospitals with three levels of care: intensive care treatment, follow-up treatment, and nursing services. The reduction of hospital capacity also allowed for the improvement of the

material-technical base of remaining facilities, and for the number of outpatient facilities to increase.

B. Strengthening Primary Care

The historic bias in the health care financing system that favors hospitals has reduced the ability of the primary care sector to provide the full range of high quality primary care services to their populations. Primary care physicians are poorly paid and lack proper equipment and supplies, which encourages high referral rates to specialists and more expensive inpatient facilities. The decline of the primary care sector is particularly acute in rural areas where, despite a well developed network of primary care facilities, utilization is falling rapidly, in part because continued underfinancing has eroded public trust in these facilities.

In Semipalatinsk, the Oblast Health Department adopted policies that strengthen primary care by transferring a greater share of health care resources to primary care and increasing the autonomy of primary care providers. This has been achieved by breaking the monopoly that hospitals have had over the delivery of health care services, and creating independent primary care entities that receive financing directly and have greater control over their resource allocation and management decisions. In addition, significant resources have been invested by the Oblast Health Department and international donors to increase the clinical capability of rural primary care providers through training, and providing adequate supplies and equipment.

1. Reorganization of Primary Care Service Delivery

In the urban areas, the Oblast Health Department began reorganizing polyclinics to create primary care “micropolyclinics” and family clinics that are administratively and financially separate from specialty-orient polyclinics and hospitals. Six micropolyclinics and 9 family clinics have been established in Semipalatinsk City and surrounding villages since 1995. Micropolyclinics and family clinics have mixed (adult and pediatric) catchment areas, so they can provide family-oriented, integrated health care with an emphasis on primary care and preventive services.

In the rural areas, the demonopolization of the Central Rayon Hospitals over the financing, administration and delivery of health care services has been achieved by separating SVAs and FAPs from the Central Rayon Hospitals and combining them into administratively independent units called SVA-FAP complexes. There are currently 129 SVA-FAP complexes in the 15 rayons that constitute the former Semipalatinsk Oblast.

The SVA-FAP complexes, micropolyclinics and family clinics are juridical entities with their own bank accounts, and receive their financing directly rather than through hospitals or polyclinics. All of the independent primary care facilities have contracts with and receive all of their financing from the Semipalatinsk Regional MHI Fund.

Since 1995, all SVA-FAP complexes, and all but two micropolyclinics and family clinics, have been converted to “property rent” status. Property rent status is a form of governmental ownership that gives the facilities increased management autonomy and financial independence, but the facilities remain part of the government health care system. The health facilities under property rent have each signed an agreement with the Oblast Health Department.

The contract for property rent transfers the right to occupy, use and manage the health facility to the “renter” (Head Doctor) for a defined period of time. The rights of ownership remain with the Territorial Government Property Committee. The property rent contract also determines the amount of rent to be paid for the facility, and defines the criteria for the volume and quality of medical services to be provided by the renter.

The Semipalatinsk Oblast Health Department actively supported the primary care facilities in the transition to property rent status to ensure that the newly independent facilities would survive and succeed. The Health Department transferred greater financial and management responsibility to the new independent primary care facilities gradually to give them time to adjust to the new system and learn how to make independent management decisions. The Oblast Health Department held numerous meetings and seminars to teach primary care physicians about the reforms and help them learn to adapt to the new environment.

The Oblast Health Department granted the facilities two years of rent relief to give them the opportunity to adapt to the new system before increasing their financial responsibility. The Health Department also worked with the SVA-FAP complexes to determine the most advantageous form of registering the new independent entities to reduce their tax burden. In addition, as part of the transition to property rent, the Oblast Health Department helped the facilities to begin to think more like businesses by requiring them to submit business plans outlining how they planned to use their resources in order to meet their commitments to the Oblast Health Department. The Health Department subsequently made the submission of annual business plans a routine reporting requirement for health care facilities.

Under property rent, the SVA-FAP complexes and micropolyclinics now have the authority to determine their staffing patterns, optimize their physical plant, and make other resource allocation decisions across the four budget chapters for which they receive funding (chapters 1, 2, 3, and 10). The health facilities under property rent, however, are still required to pay health care workers according to the national wage schedule. This constraint prevents the facilities from fully optimizing their resources by, for example, paying employees according to an incentive-based system.

Although the SVA-FAP complexes have been granted increased autonomy and independence, the Oblast Health Department and MHI Fund retain control over the facilities through the medical statistical reporting system, financial contracts and reporting, and the licensing and accreditation process. For example, in February 1997, the Semipalatinsk Oblast Health Department revoked the license and government contract of one SVA-FAP complex and one family clinic because they did not meet the Department’s quality standards. Without government contracts, these facilities are no longer eligible to receive government financing, neither from the budget nor from the MHI Fund.

The innovation in Semipalatinsk, however, is that although the government retains control over the **outcomes** of the health care system, they have reduced their control of the **process** by which health facilities achieve those outcomes. SVA-FAP complexes, micropolyclinics, and family clinics are responsible for maintaining the health of their populations, as measured by indicators of quality and health outcomes developed by the Oblast Health Department and MHI Fund. The facilities have the freedom, however, to allocate their resources in the best way to achieve high quality of care and improved health outcomes according to their particular circumstances and the health needs of their populations.

2. *Clinical Training and Equipment*

To increase the utilization and efficacy of the primary health care system, physicians must have the training and equipment to provide high quality services. The Oblast Health Department's policies to restructure primary care will lead to increased financing and utilization of the primary care sector over the long term, and the facilities will eventually have the resources to maintain adequate supplies and equipment and attract qualified physicians. In the short to medium term, however, it is essential that the facilities receive the clinical skills and tools they need to attract patients and financing.

The Oblast Health Department initiated a strategy to provide clinical training and equipment to newly independent primary care facilities. The Health Department provided grants to primary care facilities to improve their equipment and to purchase postgraduate training in general medicine. Clinical training has been provided for urban and rural primary care physicians by the Kazak Postgraduate Institute of Physicians and the Semipalatinsk Medical Academy. In addition, the strategy to strengthen primary care has been supported by grants from USAID ZdravReform and the Soros Foundation to provide equipment and training to rural primary care physicians.

III. FINANCING REFORMS

In 1996, when the MHI Fund was established in Kazakhstan, Semipalatinsk Oblast began a series of financing reforms that pay health facilities according to activity and the services they produce, rather than a guaranteed fixed budget based on capacity. The financing reforms, combined with increased management autonomy, give health facilities the incentive to manage their resources carefully to achieve the greatest health benefit for their expenditures.

A. Macro Financing

Immediately after the MHI Fund was established, the Semipalatinsk MHI Fund and the Oblast Health Department made a joint recommendation to the Oblast Akim to divide financing responsibility between the Guaranteed and Basic benefits packages so as to provide the optimal economic incentives to health facilities. The financing responsibility was divided according to health facilities rather than by type of service, so each health facility in the Oblast would receive its financing from only one source. The Oblast Health Department financed the dispensaries, ambulance services, the blood bank, SES and other high-cost specialty facilities, while the MHI Fund financed the remainder of the health facilities in the system. As a result, the MHI Fund finances about 80 percent of health services in the Oblast. This strategy reduced administrative costs, and sent clear price signals to the health facilities so they could begin to adapt their service delivery to the payment system they faced.

B. Specialty Care Financing Reforms

In accordance with the acute deficit of resources, and because all regions were subsidized, all the health care services were financed by the Oblast budget. The principal of chapter budget financing is continuing. The difference is that all the principal chapters of the expenditures (3, 9, 10, 12, 14, 16) were financed on the base of competitive bidding. The specialty services of the rayon were financed by the Health Department also from the Oblast budget. The cost of the

services with mutual settlements between the Central Rayon Hospital and the MHI Fund, these expenditures were not included.

C. Primary Care Financing Reforms

To address the chronic underfinancing of primary care and to attempt to create an adequate and stable flow of financing to the rural primary care sector, the MHI Fund decided jointly with the Oblast Health Department to implement a capitated payment system for rural primary care services. Beginning in September 1996, all SVA-FAP complexes are paid a monthly per capita rate for each individual enrolled in the facility. The payment system is not a fundholding system, because the capitated rate covers only four chapters of primary care budgets, and all referrals to specialists, diagnostic services and hospitals are financed independently by other payment systems.

The Semipalatinsk MHI Fund developed capitation rates by aggregating the annual guaranteed budgets for all independent SVA-FAP complexes in each rayon and dividing the total budget by the aggregate population enrolled in these facilities. This formula produced budget neutral rayon average capitation rates, with all SVA-FAP complexes in one rayon receiving a single capitated rate. A SVA-FAP complex's monthly payment from the MHI Fund is the rayon average capitation rate multiplied by the number of individuals enrolled in the facility.

The variation in rates across rayons is based on historical resource allocation patterns, which are determined by regional availability of budget funds and are largely independent of variations in primary health care needs of the population. This approach was adopted for the short term in order to begin the process of improving the equity of resource allocation across primary care facilities. The first stage of the payment system was accepted by rayon physicians because it did not change any facility's budget significantly, and it did not force inter-rayon transfer of resources.

Four rayons have completed an enrollment campaign, encouraging each family in the catchment area to come to the facility and fill out an enrollment card. This information has been entered into a database at the Semipalatinsk MHI Fund. The official catchment areas are used as enrollment bases for the remaining 11 rayons that did not yet complete the enrollment campaign.

To ensure that the capitated payment system and increased financial autonomy of primary care facilities does not negatively affect quality of care, the Oblast Health Department and MHI Fund developed a bonus/penalty system to link the financing of SVA-FAP complexes to their performance. A set of ten indicators of quality of care was developed, including, for example, infant and maternal mortality, infant deaths in the home, inappropriate hospitalization, and justified consumer complaints. The performance of each SVA-FAP complex is evaluated against these indicators on a quarterly basis by the MHI Fund, and the capitated payment is adjusted upward or downward according to performance. The bonus system has been implemented first as a "paper" system to give facilities the opportunity to see how their financing would have been affected by their performance during the last quarter. Full implementation of the system will begin next quarter. Because of the limited financing available to pay bonuses to facilities that perform well, a bonus pool will be established and kept separate from the general pool of financing. Any reductions in capitated payments to facilities as a result of penalties will be saved in the bonus pool to be paid out to those

facilities that perform well. In addition, the Oblast Health Department and MHI Fund won a grant from the Soros Foundation to finance the bonus pool for the first year of implementation.

The Semipalatinsk MHI Fund is prepared to move on to the next stage of refinement of the rural primary care payment system in order to disengage the payment system from historical resource allocation patterns, and to more adequately capture differences in health care needs across population groups. To accomplish these goals, the MHI Fund will gradually move toward a regional average capitation rate for the entire portion of the former Semipalatinsk Oblast financed by the Semipalatinsk MHI Fund, and apply risk adjusters that adjust capitation rates for cost variations associated with the health care needs of different population groups, for example age and sex or chronic disease diagnosis.

IV. CONCLUSIONS AND NEXT STEPS

A. Main Conclusions

The combination of financing reforms and increased independence and autonomy for health care providers to respond to the new incentives in the system have had the overall effect of creating a sense of ownership and commitment among physicians, which has already led to improvements in efficiency. These achievements have occurred even during a time of severe financial crisis in the health sector of the former Semipalatinsk Oblast. For example, one SVA in Semipalatinsk occupied a three-story building, had 27 staff positions, and used 150 tons of coal in the winter. The Head Doctor of the SVA was able to make the decision to move to a smaller building with 8 rooms, reduce the staff to 8.5 positions, and reduce the use of coal to 20 tons. Because these changes did not result in the reduction of the SVA's financing, the facility is able to use the resources saved to provide higher quality care to its population by, for example, purchasing more medicine or initiating new programs of preventive care.

The specific conclusions and lessons learned from the Semipalatinsk reform experience can be summarized as follows:

1. The combination of increased management autonomy and new financing mechanisms that pay facilities for activity rather than capacity has the greatest impact on changing the incentives faced by health care providers, and therefore leads to the greatest improvements in efficiency and quality of care. The most important lesson from the Semipalatinsk experience is that it is management autonomy, regardless of the form of ownership, that creates the incentives for providers to improve their services. Management autonomy can be achieved in various ways, and does not require that the facility be fully privatized. If providers have the security of a long term management contract and the flexibility to make significant changes in how their resources are allocated, they will have many of the same incentives as private owners to invest in improving the facility.
2. The government can maintain much control and influence over the health care system as a purchaser and regulator of the outcomes of the health care system, even as it gives up some direct control over how services are provided. The Oblast Health Department and MHI Fund in Semipalatinsk maintain strict quality and health outcome standards, and health facilities are penalized if they do not achieve them or rewarded if they exceed them. The health facilities, however, have the independence and flexibility to make changes in their

resource allocation and management in order to meet the standards by providing the highest quality care possible at the lowest cost.

3. When there are multiple sources of financing in the system, such as the MHI Fund and the government budget, optimal economic incentives can be achieved if financing responsibility is split so that each facility receives payment from only one source. If one source of financing is paying a facility according to one pricing structure, the scope for optimizing resource utilization at the facility level is greatest because facilities face clear price signals that reflect the relative costs of different services. Facilities are then able to respond by optimizing resource allocation decisions and planning for future rationalization of service delivery.
4. Semipalatinsk has succeeded by implementing its reform agenda gradually, giving facilities time to adjust to the new system. There has also been consistent education of physicians and other health care providers by the Oblast Health Department and MHI Fund throughout the reform process. Physicians are beginning to understand the purpose and the methods of the reforms, and how they can succeed in the new system. The process of changing the mentality and perspectives of physicians, however, will take time and much more education about the economic aspects of health care. Semipalatinsk has not had sufficient resources to invest in this training as much as is necessary, and therefore, many physicians are adapting very slowly to the new system. Even with insufficient formal training, however, the physicians will gradually share their experiences and learn from each other how to survive and succeed in the new environment.

B. Next Steps

The reforms in Semipalatinsk were urgently needed due to the chronic underfinancing of the health sector and the fundamental inefficiencies in the system. Without reforms, the financial crisis would have been even more debilitating to the health sector in Semipalatinsk. In order to realize the full effect of the reforms on efficiency, quality of care and patient satisfaction, however, the reforms must be allowed continue and be refined, and the level of financing in the system must be stabilized.

1. Refinement of New Payment Methods

The payment reforms in Semipalatinsk are creating a pricing system for health care services that reflects the relative costs of providing different health services. With such a financing system, health care resources can be allocated to the uses and services that produce the greatest health benefit for the least cost. The new pricing system in Semipalatinsk was begun very gradually, so there is a great need to refine the prices to disengage the payment to facilities from historical resource allocation patterns, and to more accurately capture the variations in costs of providing different services and serving different populations. The following refinements are needed to move the reforms to the next phase of development:

1. **Case-based hospital payment system according to clinical statistical groups.** The current average cost per case payment system does not capture the variation in costs of different hospital cases, and therefore hospitals may not be adequately compensated if they attract a disproportionate share of complex cases. In addition, if hospitals receive the same payment for all services, there is an incentive for them to avoid more expensive cases for which they are inadequately compensated, rather than shift resources to services that they

can provide more efficiently and effectively. Therefore, the next phase of the hospital payment reforms will be to construct weight coefficients for hospital cases according to clinical statistical groups to compensate more costly cases with higher payments to facilities.

2. **Risk-adjustment for rural primary care capitation rates.** The current average capitation rate paid to rural SVA-FAP complexes is an adequate first step, but it does not take into account variations in health needs across different population groups. For example, a SVA-FAP complex with a disproportionate share of young children or chronically ill elderly people will require more resources than a facility with a healthy adult population of the same size.

In order to make the payment more accurately reflect the costs of serving populations with different characteristics, the Semipalatinsk MHI Fund will gradually move toward a regional average capitation rate for the entire portion of the former Semipalatinsk Oblast financed by the Semipalatinsk MHI Fund, and apply risk adjusters that adjust capitation rates for cost variations associated with the health care needs of different population groups. The MHI Fund and Semipalatinsk City Health Department have initiated a detailed study of SVA-FAP complexes to determine the actual mix of services they provide, the inputs used to provide those services, and how the costs and utilization vary according to the characteristics of the population served. From the study, the MHI Fund will develop risk adjustment coefficients for population groups (age, sex, and possibly chronic disease diagnosis) to be applied to average capitation rates. This refined capitated payment system is planned to be finalized by the end of 1997.

3. **Incentive-based compensation for physicians.** New payment systems for health facilities can have only limited effects on efficiency and quality of care if physicians are not also compensated according to performance. In order to fully realize efficiency and quality gains of the new payment systems, Semipalatinsk will develop a physician compensation scheme that reflects not only the qualifications of the physicians, but also their performance. The payment system will be based on the results of the Ministry of Health's experiment outlined in Prekaz #291.

2. *Stable Levels of Financing*

Because the Oblast budget has not met its obligations to the Semipalatinsk MHI Fund for the nonworking population in a consistent manner, all health facilities paid by the MHI Fund remain chronically underfinanced. The facilities are therefore constantly in debt, and cannot exercise the new freedom they have to allocate resources more efficiently. Much has been achieved in Semipalatinsk under extremely difficult financial circumstances, but these gains will be threatened if the required budget funding is not transferred to the health care sector. Only if health care providers receive adequate and stable financing can they take the necessary risks and make the investments required for real and sustainable improvements in the delivery of health care services.

Draft
**Plan for the Continuation of the Comprehensive Health Reform Program in Semipalatinsk
City, East Kazakhstan Oblast**
March-December, 1999

I. Introduction

Since 1995, the City of Semipalatinsk has been implementing a comprehensive health reform program that has the dual objectives of improving the quality of health care for the population, while at the same time increasing the efficiency of the health care system. To simultaneously accomplish these two objectives under conditions of severe budget constraints, the overall strategy has focused on transferring a greater share of health care resources and service delivery to the primary care sector, where the majority of the health problems faced by the population of Semipalatinsk can be diagnosed, treated and managed most cost-effectively. This overall health reform strategy is consistent with the policy of the Committee on Health of the Ministry of Health, Education and Sport, and forms the basis of the upcoming World Bank-financed Health Sector Project, which will be implemented first in East Kazakhstan and Almaty Oblasts.

The first stage of the health reform program in Semipalatinsk focused on optimizing the health services delivery system. The hospital sector was reorganized and consolidated to optimize the supply of beds, and the polyclinic sector was reorganized to create a network of primary care practices located close to the population, which provide integrated, family-centered health care. Outpatient specialty care is provided by streamlined outpatient consultative centers, upon referral by family physicians.

The restructuring of the delivery system that has already taken place provides the necessary conditions for the next phase of reforms, which involves the introduction of market mechanisms and competition into health care system through new provider payment methods and greater involvement and choice for the consumers of health care. New market mechanisms will ensure that limited health care resources are used rationally to achieve the greatest health gain for the population. Family physicians will be at the center of the new health care market to ensure that resources are used most effectively by providing a wider range of services in an integrated manner, guiding patients through the health care system and coordinating the full range of patient care.

II. Specific Objectives of the Reform Program

1. Strengthen the primary care sector to provide a wider range of services in an integrated and cost-effective manner to the population.
2. Streamline the outpatient specialty and hospital sectors, so that resources are concentrated in fewer facilities to achieve a higher material and technological base.
3. Improve the efficiency of health care resources by shifting resources to primary care and introducing market mechanisms through new provider payment methods and greater choice of provider.

4. Increase population involvement in their own health care through information, choice, and the promotion of healthy lifestyles.

III. Summary of Achievements

During 1998, the structure of the health care delivery system in Semipalatinsk was reorganized to bring primary care closer to the population and to consolidate and streamline outpatient specialty and hospital services. Between July and November 1998, 19 family group practices were added to the existing 10, bringing the total to 29 family group practices located throughout the city, one of which is a training family practice of the Semipalatinsk Medical Academy. All 29 SVAs are independent juridical entities, six of which are private.

To achieve the goal of making health care integrated, family-centered and closer to the population, catchment areas were reconstructed according to a territorial principle, and adult and pediatric catchment areas were combined. Each SVA has an enrolled population of between six and eleven thousand adults and children. Physicians enrolled their populations during an enrollment campaign, which allowed the population to enroll in SVAs according to their actual place of residence, rather than where they are registered in order to improve access to primary care.

Each SVA has on its staff a group of physicians, which includes pediatricians, therapists and akusher-gynecologists to provide integrated care to the entire family, and a new position of practice manager to introduce new management techniques and information systems. The Head Doctors and managers were selected through an open competitive process. All practice managers were trained and certified in the government accounting system, and received two months of intensive training in the principles of health management.

An information campaign was conducted during the first phase of the reforms through television, radio and newspapers to inform the population about the reform process, inform them of their rights and responsibilities, and to answer their questions and concerns.

IV. Continuation of Reform Program

The next phase of the reforms in Semipalatinsk City will focus on creating market conditions in the health care system to improve efficiency and quality of care, and further strengthening the primary care sector to provide a greater share of health care services. Market conditions and the improved efficiency and effectiveness they can bring will be achieved by coordinating reforms in financing and service delivery across all components of the health care system.

A. Improving Clinical Capacity of Primary Care

1. Continue clinical training in general practice/family medicine for SVA physicians and nurses.
2. Provide clinical training necessary to integrate vertical programs into primary care services, including tuberculosis, integrated management of childhood illnesses, and reproductive health and family planning.

3. Provide targeted clinical training in specialty areas.
4. Continue ongoing self-training and cross-training within the SVAs

B. Create Market Conditions in the Health Care System

1. Create equal conditions in SVAs, including equipment and size of population, then allow SVAs to distinguish themselves through quality of care and emphasis on comfort and convenience of patients.
2. After several months working under equal conditions, the population will have the opportunity to choose their SVA through open enrollment.
3. The financing system will be based on a per capita principle, with one average capitation rate for all SVAs, adjusted by age/sex coefficients.
4. The outpatient specialty sector will be forced to compete for patients referred to them by SVAs. To achieve this, SVAs should have free choice of referral to consultative centers, either by choosing one consultative center to which to refer all of its patients, or having the option to choose a different center for the referral of different patients.
5. Consultative centers will be financed according to a fee schedule, which is the same for all centers. The fee schedule is made up of a base rate and relative weights for a range of specialty services. The base rate is determined by the amount of funds available for outpatient specialty care, and the relative weight coefficients will be provided by the National Committee on Health and Center for Health Purchasing.
6. Hospital care will be financed on a case-based system according to clinical statistical groups. The new hospital payment system is also made up of a base rate determined by the funds available for hospital care, and relative weights provided by the National Committee on Health and Center for Health Purchasing.

Workplan for September-December 1998.
(e-mail version: admin/workplan_fall98.doc)

1st draft for discussion: September, 1998

ACTIVITIES	RELATIVE DOCUMENTS AND E-MAIL COPIES	DATE	RESPONSIBLE PERSONS
I. TOT ON SVA MANAGEMENT			
<p><i>Detailed plan of TOT training course is attached.</i></p> <p>**ZdravReform staff should start preparing presentations, study materials and manuals immediately; responsible persons are presented in a draft of study program attached.</p>	<p>Training on management /conceptfin.doc; /training_rus.doc; /mgmt_plan.doc; /mgmt_plan_rus.doc</p>	<p>TOT: October 26- November 7 Training of practice managers (Semipalatinsk): November 23- December 11 (Fergana): November 30- December 18</p>	<p>Michael Borowitz, Bred Else, Olga Zuez, material-technical provision (TBD)</p>
II. SEMIPALATINSK			
	<p>Preparing of documents on Semipalatinsk 3: PHC reforming; plan signed by Akim of city. Electronic copy is available in Gennady's PC in Semipalatinsk; English translation has been done by Gulya</p>		<p>Michael Borowitz, Olga Zuez</p>
A. Enrollment campaign	semipalatinsk/restructure/enroll regs0608.doc		
Develop database on population enrollment		Until mid-September	Gennady Simakov
Conduct training of PHC physicians on data collection		At the beginning of September	Gennady Simakov, Aliya Begalina

Conduct enrollment campaign (data collection, coordination and monitoring, collection of filled forms/cards)		From mid-September to mid-November	SVA, Gennady Simakov, Aliya Begalina
Enter data		From end of September to the beginning of December	Gennady Simakov
Make an analysis and summarize data on population enrollment		From mid-November to the end of December	Gennady Simakov
B. Information campaign	Plan on information campaign in Semipalatinsk, Book 3		
Conclude a contract with consultant Victoria Rotaro		Up September 9	Cheryl Wickam, David Miller
Explain to consultant the procedure of invoices submission		Till the beginning of September	Olga Zuez
Complete issue of brochure and send it to Semipalatinsk		Till the beginning of September	Olga Zuez, Natasha Danilenko
Disseminate brochures among population		From mid-September to mid-November	SVA, Aliya Begalina, Olga Zuez
Issue newspaper articles and radio transmission		September	Victoria Rotaro, Aliya Begalina
C. Payment systems of Consultative Centers based on fee schedule	Signing of documents on Semipalatinsk 3		Olga Gubanova
Complete revised version of fee schedule		Till September 11	Olga Gubanova
Complete estimation of pooled funds of outpatient-policlinic sector and base rates		Till mid-September	Olga Gubanova
Define payment system of Consultative Centers for immunization, but based on capitated rate paid to PHC facilities		Till September 11	Cheryl Wickam, Olga Gubanova
Develop regulations on payment system based on fee schedule		Till September 11	Cheryl Wickam, Olga Zuez
Discuss the status of affairs with the working group, physicians and economists of Consultative Centers (CC)		Mid-September	Olga Gubanova, Aliya Begalina

Conduct seminar on informing of CC's staff on new payment system		October	Olga Gubanova
D. Capitated PHC payment system			
Complete estimation of capitated rate, if possible, including costs of outpatient provision of children with drugs (diarrhea, ARD/ARI)		Till the end of September	Olga Gubanova, Olga Zuez
Make a review of visits/encounters in order to calculate sex-age adjustment coefficient		October, November	Olga Gubanova, Olga Zuez, Aliya Begalina, Gennady Simakov
-modify questionnaire	Semipalatinsk/risk/risk.xls	Till the end of October	Olga Zuez, Aliya Begalina
-type forms		Till the end of October	Olga Zuez
-select SVA (having various population, include Student polyclinic)		October	Olga Zuez, Aliya Begalina
-previous revision and training of staff of facilities on data collection (2-3 weeks)		October-November	Olga Zuez, Aliya Begalina
-collect data (2-3 weeks); monitoring and quality control			Olga Zuez
-complete questionnaire for facilities participating in review		October	Olga Zuez
-modify software on data enter		Till mid-November	Gennady Simakov
-enter data		November-December	Gennady Simakov
-make data analysis		December	Gennady Simakov, Cheryl Wickam, Olga Zuez
Conduct seminar on new capitated payment system		December	Olga Zuez, Olga Gubanova
E. Hiring and training of practice managers			

<i>More detailed plan of study course is attached.</i>	Training of managers /conceptfin.doc; /training_rus.doc; /mgmt_plan.doc; /mgmt_plan_rus.doc	TOT: October 26 – November 7 Training of practice managers (Semipalatinsk): November 23 – December 11	
Complete development of job description for practice managers	Book on Kyrgyzstan	Till mid- September	Olga Zuez, Aliya Begalina
Conduct seminar for candidates on position of practice manager and head physician; as well as conduct selection of practice managers based on competition		3 rd or 4 th week of September	Olga Zuez, Aliya Begalina
-agree previously with Rosa Abzalova and Inna Stratulat from Zhezkazgan on their participation in seminar; manage material-technical provision issues		Till September 11	Cheryl Wickam, Olga Zuez
-develop plan of seminar		Till mid- September	Olga Zuez, Aliya Begalina
-develop guidelines on interviews with potential candidates on the position of practice managers and situational questions for examination		Till September 11	Cheryl Wickam, Olga Zuez
Develop plan of joint training with Medical Academy and Semipalatinsk University	Book on Semipalatinsk #3, terms of contract in Russian developed by Askar Chukmaitov	Till September 30	Olga Zuez, Aliya Begalina, Brad Else, representative of Institute
Provide accounting training courses for practice managers without accounting background in Semipalatinsk University	conceptfin.doc	Till September 30	Olga Zuez, Aliya Begalina
F. Create information network for PHC facilities		Till December	
-develop forms on PHC services and referral forms. Use the forms of Zhezkazgan and Kyrgyzstan, be sure that data will be consistent with the existing database		Till mid-October	Gennady Simakov, Zhenya Kutanov, Aliya Begalina, head specialists of Semipalatinsk HD, Olga Gubanova

-discuss forms with physicians and make amendments		Till mid-October	Aliya Begalina, Head specialists of Semipalatinsk HD
-forms of previous test and their completion		Till the end of October	Gennady Simakov , Aliya Begalina
-create system of forms collection and data enter		Till the end of November	Gennady Simakov , Aliya Begalina Aliya Begalina, Olga Gubanova
-conduct seminar for SVA, Consultative Centers and hospitals on use of information systems		Till mid-December	Gennady Simakov , Aliya Begalina, Olga Gubanova
-adapt existing database available in other pilot cites		Till mid-December	Gennady Simakov
-put into operation new information system		Up to January 1	Gennay Simakov , Aliya Begalina, Olga Gubanova
G. Strengthening of SVA			
Give a grant on renovation and equipment procurement (Michael promised US\$ 50.000 to deputy Akim of Semipalatinsk)		Up to January 1	Michael Borowitz , Aliya Begalina
Assess a volume of renovation required for new and existing SVA		Mid-September	Nikolay Shulyakovsky
Continue work with Tatyana Lukina on her request to create model SVA in new one assigned to Maternity House #3		Mid-September	Michael Borowitz
Continue work with Mukhtar Tuleutaev on study of his guidelines on unifying of vertical program with PHC sector and, probably, their further issue as a national guideline		Till the end of September	Michael Borowitz , Damilya Nugmanova
H. TB			
Develop plan on DOTS-strategy implementation with further phased-in realization through SVA:	National Plan on TB control (Grace)		Michael Borowitz , Grace Hafner, Amanda Cooper
-provide with lab equipment and supplies			
-conduct training of lab workers			

-review a problem of moving of TB dispensary physicians to SVA			
III. FINANCE AND MANAGEMENT COMPONENT IN UZBEKISTAN			
A. Capitated payment system			
Continue work with Oblast and National officials on completing of capitated rate, if possible, include outpatient drug procurement for children (diarrhea and ARI)	Uzbekistan/Olga/cap_rate.xls Olga has a final version of Governmental Decree (to be translated to English)		Hamdia Ramich, Olga Zuez
Develop jointly with Oblast officials and SVA plan on use of additional funds			Hamdia Ramich, Olga Zuez, George Right (?)
Make an analysis of lab capacities and needs in services. Define the services at the level of PHC funded based on increased capitated rate		September 15-24 ?	Amanda Cooper, , Hamdia Ramich, Michael Borowitz
Conduct seminar for new capitated payment system implementation		October December (when calculation of sex-age adjustment coefficients will be completed))	Olga Zuez , Hamdia Ramich, Michael Borowitz
B. Sex-age adjustment coefficients			
Complete previous assessment and data collection in last two rayons		September 7-26	Olga Zuez, Feruza
Complete data enter		Up November 15	Anton, Gennady Simakov
Make an analysis of encounters data		November-December	Cheryl Wickam, Gennady Simakov, Cheryl Wickam, Olga Zuez
Make an analysis of costs	Semipalatinsk/riskcost.xls	November	Olga Zuez, Cheryl Wickam,
Estimate sex-age adjustment coefficients	Semipalatinsk/riskcost.xls; Service.xls	Up December 15	Olga Zuez Cheryl Wickam,
C. Hiring and training of practice mangers			

<i>More detailed training courses plan is attached.</i>	Training on management /conceptfin.doc; /training_rus.doc; /mgmt_plan.doc; /mgmt_plan_rus.doc	TOT: October 26- November 7 Training of managers (Fergana): November 30- December 18	
Complete development of job description for practice managers	Book on Kyrgyzstan	Till mid- September	Hamdia Ramich, Olga Zuez
Conduct seminar for candidates on position of practice manager and head physician as well as conduct selection of practice managers based on competition		Till mid- September	Hamdia Ramich, Olga Zuez
Provide accounting training courses for practice managers without accounting background in Fergana State University	conceptfin.doc	Up September 30	Olga Zuez, Hamdia Ramich,
IV. CONFERENCE ON MOTIVATION OF MEDICAL WORKERS CONDUCTED BY PHR			
	Training on management /phr_kazakhstan. doc (version of document submitted by PHR on September 5, 1998)	Rosa in Almaty, one week since September 21 Conference: October 14-16 in Bethesda	Cirsty Bernet, Damilya Nugmanova
Complete conducting of agreements with consultants— Rosa Abzalova, Askar Chukmaitov, Cheryl Wickam	PHR/Human resources file. All PHR materials are available in my bookcase	Up September 11	Cheryl Wickam, David Miller
Make a trip schedule of Rosa Abzalova		Up September 11	Natasha Kairgeldina, Cirsty Bernet ??????
Translate document to Russian (time should be billed to PHR)		Up September 30	Liza Myglina

Assist Rosa Abzalova in preparing of slides (in Russian and English)		September 21-26 (depends on her visit to Almaty for meeting of board)	Damilya Nugmanova , computer specialists and interpreters (TBD)
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PROPOSED PLAN FOR THE CONTINUATION OF REFORMS IN THE FORMER SEMIPALATINSK OBLAST

October 1997 - 1998

I. INTRODUCTION

In response to the severe underfunding of the sector and in order to comply with the Government of Kazakhstan's Midterm Program of 1995-1996, Semipalatinsk Oblast initiated a health reform program in 1995 that included the following components: reorganization of the financing and management of health care, restructuring and rationalization of health care facilities, and transfer of governmental facilities to non-governmental status and private ownership. The reform program in Semipalatinsk Oblast was initiated with a decision of the Oblast Maslikhat (Parliament) on December 23, 1994. The reform program had the goal of moving the health care system to a market-based system in response to the financial crisis in Semipalatinsk Oblast. New financing mechanisms were introduced to give the appropriate economic incentives to health care providers, and increased management autonomy was given to health care providers so they can freely respond to the new incentives in the system. In addition, a program was undertaken to rationalize the hospital sector and strengthen the more cost-effective primary care sector through material support, clinical training and policies that actively shifted resources and decision making authority to this sector. Please see Attachment 1 for a detailed description of the reform activities to date in the former Semipalatinsk Oblast.

The reforms in Semipalatinsk have been extensively evaluated by the Ministry of Health (MOH), the Mandatory Health Insurance (MHI) Fund, and outside organizations such as the USAID ZdravReform Program. Based on these evaluations, the MOH has decided that the reform experiments in Semipalatinsk should continue and expand. The current document is in response to the MOH request for a detailed plan for the continuation of reforms in the former Semipalatinsk Oblast, now referred to as the Western region of East Kazakhstan Oblast, over the period October 1997-1998.

II. GOALS AND OBJECTIVES OF THE EXPERIMENT

The health reform experiment will continue in the direction initiated by the Semipalatinsk Oblast Health Department in 1995 and the Semipalatinsk MHI Fund in 1996. The general goals remain as follows:

1. Continue decentralization and privatization in the health sector, and increase management and financial autonomy for health care facilities. In addition, increase the role of non-governmental organizations in the health sector.
2. Continue to create the conditions for a health care market, including a public-private mix in the delivery of health care services and informed consumer choice of health care provider.

3. Continue to restructure the health service delivery system to shift resources and service delivery from the large, inefficient hospital sector to the more cost-effective primary care sector.
4. Continue to strengthen the primary care sector through new organizational structures and financing mechanisms, clinical training and adequate equipment to increase the capacity of the primary care sector to provide a greater share of health services.
5. Continue to improve the quality of health care services.
6. Improve the population's health through public information campaigns and the promotion of healthy lifestyles.

III. EXPECTED INTERMEDIATE RESULTS OF THE EXPERIMENT

The expected intermediate results of the experiment are as follows:

1. New payment systems for health care providers that provide economic incentives to improve efficiency and quality of care.
2. Increased management and financial autonomy for health care providers to make resource allocation and other management decisions.
3. Competition among public and private health care providers.
4. A greater proportion of funding allocated to and health care services provided through the primary care sector.

IV. EXPECTED RESULTS

Over the longer term, it is expected that the reform experiment will lead to the following results:

1. Greater consumer choice and improved patient satisfaction.
2. Greater efficiency in the allocation of health care resources.
 - a) Reduced hospitalization, fewer hospitals and beds, and reduced length of hospital stay
 - b)
3. Increased utilization of and confidence in the primary care sector.
4. Higher quality of health care services.

V. ACTIONS

No.	Actions	Date	Issues and Constraints	Responsible Agencies
I.	Establish Local Health Reform Implementation Group	Immediately		1 Representative each from East Kazakhstan Oblast Health Department and MHI Fund; Semipalatinsk City Health Department; Association of Family Physicians; 2 representatives from Semipalatinsk Regional MHI Fund
II.	Macro-Financing			
A.	Create a unified health budget for the Western region of East Kazakhstan Oblast (Health Reform Experiment Site).	1998	According to the decision of East Kazakhstan Oblast, health budgets are allocated at the rayon level and cannot be pooled.	East Kazakhstan Oblast Akim
B.	Maintain the independence of the Semipalatinsk Regional MHI Fund for the duration of the health reform experiment.	1997-1999	Semipalatinsk Regional MHI Fund independence is currently guaranteed only until December 1997.	Oblast Akim; Oblast MHI Fund; Federal MHI Fund
C.	Grant authority to the Semipalatinsk Regional MHI Fund to finance all health facilities in the Health Reform Experiment Site, with the exception of those facilities financed through the budget under the Guaranteed Package of Benefits (e.g. dispensaries, blood bank, ambulance services, etc.)	1997-1999		East Kazakhstan Oblast Akim, Oblast Health Department, Oblast MHI Fund, Federal MHI Fund
D.	Define the Guaranteed and Basic Benefits Packages and divide financing responsibility between the Semipalatinsk MHI Fund and Oblast Health Department so that each health facility receives financing from only one source.	Develop: 4 th qtr. 1997 Implement: 1 st qtr. 1998		East Kazakhstan Oblast Akim, Oblast Health Department, Oblast MHI Fund, Federal MHI Fund, Semipalatinsk Regional MHI Fund
E.	Develop a mechanism for transferring funds on a per capita basis from the Oblast budget to the Semipalatinsk Regional MHI Fund in a consistent and timely manner.	Develop: 4 th qtr. 1997 Implement: 1 st qtr. 1998		East Kazakhstan Oblast Akim
F.	Develop mechanism for Semipalatinsk MHI Fund to establish a reserve fund so payment systems can remain stable when MHI Fund revenues fluctuate.	Develop: 4 th qtr. 1997 Implement: 1 st qtr. 1998	Budget funds in the MHI Fund's bank account are currently not permitted to be carried over into the next year.	East Kazakhstan Oblast Akim, Oblast Health Department, Oblast MHI Fund, Federal MHI Fund
G.	Analyze options for aligning the government health care commitments with available resources: reducing the benefits package, targeting benefits, and introducing copayments.	1 st -2 nd qtr. 1998		Oblast Akim, Oblast Health Department and Semipalatinsk Regional MHI Fund
III.	Organization and Management of Service Delivery System			
A.	Decentralization and Privatization			
A1.	Analyze the options for organizational structure and juridical status	1 st qtr. 1998		Oblast and City Health Departments;

	of health facilities to increase financial and management autonomy.			National Health Reform Working Group
A2.	Develop a plan for privatization of health facilities that is consistent with the national privatization strategy.	1 st qtr. 1998		Oblast and City Health Departments
	Implement privatization plan.	2 nd -4 th qtr. 1998		Oblast and City Health Departments
B.	Integrated Clinical and Financial Information System			
B1.	Identify information to be collected, develop data collection forms and computer software. Develop plan for unifying data system between Health Department and Semipalatinsk Regional MHI Fund. Identify computer hardware needs.	1 st -2 nd qtr. 1998	Reporting forms required by Federal MHI Fund and MOH duplicate information, place administrative burden on facilities, and cannot be integrated and analyzed for policy development or facility management.	Oblast and City Health Departments, Semipalatinsk Regional MHI Fund, Federal MHI Fund, MOH, Ministry of Finance
B2.	Implement integrated clinical and financial information system.	3 rd qtr. 1998		
C.	Management Training			
C1.	Develop and implement a management training plan for staff at all levels of the health care system.	1998		Oblast and City Health Departments and Semipalatinsk Regional MHI Fund.
C2.	Train all health facilities to prepare annual business plans and establish them as a routine reporting requirement.	1 st -2 nd qtr. 1998		Oblast and City Health Departments
D.	Primary Care Restructuring			
D1	Primary Care—General			
D1.1	Determine scope of services to be provided in primary care sector.	Completed by 2 nd qtr. 1998	Current norms and precizes governing clinical practices limit the services that can be provided in the primary care setting.	Oblast and City Health Departments; MOH
D1.2	Determine training and equipment needed to provide basic set of primary care services.	Completed by 2 nd qtr. 1998		Oblast and City Health Departments; MOH
D1.3	Develop long-term training strategy for primary care physicians	Completed by 2 nd qtr. 1998		Oblast and City Health Departments; Semipalatinsk Medical Institute; MOH
	Strengthen capacity of Semipalatinsk Medical Institute to provide undergraduate training and postgraduate retraining in general/family medicine.	1998		Oblast and City Health Departments; Semipalatinsk Medical Institute; MOH
	Establish urban and rural training practices for clinical training in general/family medicine in conjunction with the Semipalatinsk Medical Institute.	1998		Oblast and City Health Departments; Semipalatinsk Medical Institute; Family Physician Association
D1.4	Strengthen the Family Physician Association.			
	Create an East Kazakstan Western Regional Association of Family Physicians	4 th qtr. 1998		Family Physician Association; Oblast and City Health Departments
	Provide training in management and organization of non-governmental organizations.	1998		Oblast and City Health Departments; Family Physicians Association
D1.5	Conduct a public information and health promotion campaign about	1998		Oblast Health Department; Family

	the role of primary care in preventing, managing and treating the most prevalent infectious and chronic diseases.			Physicians Association
D2.	Primary Care—Urban			
D2.1	Continue to restructure all polyclinics into independent micropolyclinics for primary care and consultative polyclinics for referrals.	Completed by 2 nd qtr. 1998		Oblast and City Health Departments
	Establish all micropolyclinics as independent juridical entities with their own bank accounts.	Completed by 2 nd qtr. 1998		Oblast and City Health Departments
	Create mixed catchment areas for all micropolyclinics.	Completed by 2 nd qtr. 1998		Oblast and City Health Departments
D2.2	Strengthen the clinical skills and material base of micropolyclinics.			Oblast and City Health Departments
	Provide clinical retraining in general/family medicine to all micropolyclinic physicians	completed by 4 th qtr. 1998		
	Provide a basic set of equipment to all micropolyclinics.	completed by 4 th qtr. 1998		
D2.3	Hire and train practice managers for micropolyclinics	completed by 4 th qtr. 1998		Oblast and City Health Departments; micropolyclinics
D2.4	Open enrollment in urban micropolyclinics.			
	Conduct a public information campaign about the new structure of primary care and free choice of primary care provider.	1 st qtr. 1998		
	Conduct an open enrollment campaign in which each family has the opportunity to choose a micropolyclinic.	2 nd qtr. 1998		Oblast and City Health Departments; Family Physicians Association
	Enter enrollment data in database at MHI Fund and/or in micropolyclinics.	2 nd -3 rd qtr. 1998		MHI Fund; Micropolyclinic staff
D3.3	Primary Care--Rural			
D3.1	Continue strengthening independent SVA-FAP complexes			
	Provide clinical retraining in general/family medicine to all SVA physicians	completed by 4 th qtr. 1998		
	Provide a basic set of equipment to all SVA-FAP complexes.	completed by 4 th qtr. 1998		
D3.2	Continue enrolling population in SVA-FAP complexes and entering enrollment data into MHI Fund enrollment database.	Completed by 2 nd qtr. 1998		Semipalatinsk Regional MHI Fund
E.	Outpatient Specialty Care Restructuring			
E1.	Determine appropriate organizational structure and juridical status for outpatient specialty facilities.	1 st qtr. 1998		Oblast and City Health Departments
E2.	Develop rationalization plan for outpatient specialty facilities.	1 st and 2 nd qtr. 1998		Oblast and City Health Departments
E3.	Implement rationalization plan for outpatient specialty facilities.	3 rd qtr. 1998-2 nd qtr. 1999		
F.	Hospital Restructuring			
F1.	Develop a hospital rationalization plan—including internal	1 st -2 nd qtr. 1998		

	restructuring of hospital services, and closure and merger of hospitals.			
F2.	Implement hospital rationalization plan	3 rd qtr. 1998-4 th qtr. 1999		
IV.	Provider Payment Systems			
A.	Hospital Payment System			
A1.	Develop a case-based hospital payment system based on clinical statistical groups			
A1.1	Develop hospital case reporting/billing form (adapt form currently used in Zhezkazgan)	4 th qtr. 1997		Semipalatinsk Regional MHI Fund; Oblast Health Department
	Develop data bases for hospital cases.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
	Begin collecting hospital case data in urban hospitals and 2-4 Central Rayon Hospitals.	1 st qtr. 1998		Semipalatinsk Regional MHI Fund
A1.2	Develop clinical statistical groups and weight coefficients. Begin by using Zhezkazgan case weights, and using patient-level data to refine weights over time.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund; Oblast Health Department
A1.3	Develop base rate for hospital payment system.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
A1.4	Train physicians on new payment system.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
A2.	Implement refined case-based hospital payment system in urban hospitals and 2-4 Central Rayon Hospitals.	1 st qtr. 1998		Semipalatinsk Regional MHI Fund
B.	Outpatient Specialty Payment System			
B1.	Analyze the options for outpatient specialty payment system: completed case, fee schedule, or block contracts. If a partial fundholding system is planned, the relationship between primary care and outpatient specialty facilities must also be analyzed.	4 th qtr. 1997-1 st qtr. 1998		Oblast MHI Fund; Semipalatinsk Regional MHI Fund; Oblast Health Department
B2.	Develop and implement new outpatient specialty care payment system.	2 nd -4 th qtr. 1998		Semipalatinsk Regional MHI Fund
C.	Primary Care Payment System			
C1.	Primary Care Payment—Rural			
C1.1	Develop region-wide, risk-adjusted capitated payment system for rural primary care.		Requires regional pooling of health funds. In addition, this payment system is only effective if the banking laws are changed so that health facilities have greater autonomy over their expenditure decisions.	
	Develop risk adjustment coefficients for rural primary care capitation rates.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
	Develop region-wide rural primary care capitation rate for Health Reform Experiment Site.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund

	Implement refined capitated payment system for rural primary care.	1 st qtr. 1998		Semipalatinsk Regional MHI Fund
C1.2	Refine bonus/penalty system for rural primary care capitated payment system.	1 st qtr. 1998		Semipalatinsk Regional MHI Fund
C2.	Primary Care Payment—Urban			
C2.1	Develop a capitated payment system for micropolyclinics			
	Calculate capitated rate from pooled 1997 micropolyclinic budgets and catchment populations.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
	Analyze population data from micropolyclinic catchment areas and apply risk adjusters to capitated rate.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
	Adapt bonus/penalty system to urban micropolyclinics.	4 th qtr. 1997		Semipalatinsk Regional MHI Fund
C2.2	Implement capitated payment system for micropolyclinics.	1 st qtr. 1998		Semipalatinsk Regional MHI Fund
D.	Physician Payment System			
D1.	Analyze the results of the MOH experiment on physician payment.	1 st qtr. 1998		Oblast Health Department; MOH
D2.	Develop a system of physician payment that is related to performance.	1 st qtr. 1998	Current laws create a rigid salary structure for physicians that is unrelated to performance.	Oblast Health Department; MOH
D3.	Implement new physician payment system in selected urban and rural facilities.	2 nd qtr. 1998		Oblast Health Department; MOH