

REPORT
OF THE DEPUTY HEAD OF THE
OF THE HEALTH CARE DEPARTMENT
MELNIKOV MIKHAIL NIKILAEVICH

ON LEADERSHIP OF THE ACTIVITIES
RELATED TO MEDICAL CARE QUALITY
MANAGEMENT IN NOVOSIBIRSK OBLAST

The oblast health care department had been aware of the problem of medical care quality management before Abt Associates, Inc. started its work in Novosibirsk. The data was obtained from foreign special printed matter and the concept was considered by our employees as somewhat obscure and not of the first priority. In the course of discussions with the leading medical personnel the problem was raised a number of times but without clear understanding of its concept. There was an opinion that the system of quality control should be transformed into the system of quality assurance, however no definition of these concepts had ever existed. Later on it became clear that quality control, quality assurance and quality management - are all different definitions, although this realization only occurred at the end of 1995.

Before the office of Abt Associates, Inc. was opened in Novosibirsk, the leaders of the Zdravreform project: James Rice, Lonna Milburn-Tkachenko, Stanley Tillinghast, Igor Sheiman and others visited our city. The joint discussions held at the time were fairly unusual and interesting although it was still quite difficult to visualize any concrete joint actions that could follow their visits. Soon afterwards the office of Abt Associates, Inc. was opened, the first coordinator and supervisor of the joint activity on behalf of the oblast health care department being Nikita Tov, the first deputy head of the department at the time. A number of working sessions were held with the participation of the head of the department - Vadim Filatov and the head of the TMHI fund - Andrei Reshetnikov. Such areas for the joint activities as Cherepanovo health care budget reform project was identified. In September 1995, the former head of the oblast health care department, Vadim Filatov, informed me about my appointment as a coordinator on the quality management project which presumed my close cooperation with Dr. S. Tillinghast.

Before our first meeting with Dr. Tillinghast a fairly complicated work aimed at identification of priority problems on the territory of the Novosibirsk oblast, needed to be carried out. The materials provided by the American party confirmed that a considerable part of their success in the sphere of quality management could be assigned to introduction of the quality management theory developed by Deming and Juran into various aspects of management. A number of specialists in the sphere of health care system management were provided with an opportunity to study both theoretical and practical aspects of the theory in the course of the guest tours to the health care facilities of the USA implemented within the framework of the Russian-American intergovernmental agreement on Zdravreform project. However the person who benefited most from the above tours was the deputy head physician of the Municipal hospital N 1 - Irina Nagornaya. She had delivered and arranged translation of the special methodological literature, prepared a fairly detailed report on the results of her training tour containing the information obtained on theoretical and practical achievements in the area of introduction of the quality management theory in the American health care system, which she had reported at one of the briefings at the oblast health care department. The data submitted by Mrs. Nagornaya confirmed

a considerable role of the quality management theory in the organization of the medical and diagnostic process in hospitals, in the possible ways to resolve the problems facing our medical facilities. Besides she had also introduced us to some information about some of the medical insurance companies of the USA, namely, Keiser Permanente company.

In this relation it is worth noting that by 1995 it had been already two years since the "Law on medical insurance of the RF citizens" was introduced on the territory of the Novosibirsk oblast. About half of the medical facilities had already been participating in mandatory health insurance. The joint working experience of insurance companies and medical facilities demonstrated the first both positive and negative results. Without dwelling on the former one, it is necessary to point out that one of the problems turned out to be confrontation between insurance companies experts and representatives of medical facilities, associated with too much of a stress laid upon the formal part of the medical paper work without consideration of a final result achieved while treating a patient. A more detailed account of the way the problem was settled will be given below, however it is necessary to stress that this way was obtained due the very information about the medical expertise procedure employed by the Keiser Permanente company.

The next problem of priority was that of nosocomial infection, its control and methods of fighting it. In one of our talks with Dr. Tillinghast we asked for the assistance of our American colleagues and met with complete mutual understanding of the problem. Moreover, not being an expert in this problem himself, the doctor promised to address it to the project administration staff in order to bring over some competent specialists from the USA. A working team of epidemiologists, representatives of the organs of state sanitary and epidemiological supervision and a bacteriologist was set up to work specifically in that direction. After the visit of our American colleagues and development of the specific program of actions, the working team set to work, their report having been submitted to the Abt Associates, Inc. office.

The most surprising result of our American colleagues visit here was that it has completely changed our concept of the ways nosocomial infections spread, of the preventive and control measures to fight them. Here are some examples to demonstrate it: representatives of the sanitary and epidemiological supervision service used to pay a lot of attention to the investigation of bacterial flora, cultured from air and walls of a medical facility, surgeon's hands in the operation room, etc. However it was found out that the source of nosocomial infections is medical personnel - mostly physicians and nurses contributing to passing antibiotic-resistant microflora from patient to patient, from unit to unit. Besides, the washing facilities available for patients in every ward are insufficiently used to prevent infections and are structurally imperfect. The American colleagues proposed a very simple method of treating hands after examination of a patient, used in the USA. It does not require any serious investments and consists in the fact that a medical employee should always have a gel on him in the pocket, containing a chlogexidine solution, which is to be used each time after a patient is examined. In my opinion, the most surprising turned out to be their recommendations related to the development of nosocomial pneumonia and urogenital infections in treating patients in resuscitation units.

Another problem - that of medical materials and drugs procurement and supply management - was proposed for consideration by the American party. It is known that Russian clinics are allowed to purchase medications at their own discretion from their own budget. However the decision about the list of medications to purchase is often taken fairly subjectively, the decisive vote as to what drugs and where to buy

frequently belongs to the head physician of a hospital. It should be born in mind that in this case his interests may go contrary to the needs of medical - diagnostic process. Our American colleagues helped us understand what the best way is to arrange the optimal scheme of ordering medications - the system of hospital formulary. This system is also aimed at saving hospital costs, which is of special importance under the present economic situation.

In the first decade of August our American colleagues sent us the methodological material in the form of a diskette which is expected to help us considerably in the work of the hospital formulary committees.

One of the issues for joint development was proposed by Dr. Tillinghast in relation to his own specialty - cardiology. He told us about the experience of the cardiologists from the Kemerovo oblast who had studied the experience of infarction patients rehabilitation in the USA. The Kemerovo cardiologists introduced the experience of treatment of this type of patients in their own clinics based on the American methodology and they succeeded in reduction of the hospital length of stay of the patients at an average from 40 to 13 days. Two of the experts of our department got interested in this problem and are currently working on it.

Here I could probably finish the introductory part of the report which was aimed at giving some brief background information on the initial stage of medical care quality management and the reasons at the bottom of selecting problems for development.

Issuing of the document called "Health Care Department Proposals on the Medical Care Quality Assurance" can be considered a starting point of the project implementation. They relate to the changes in the work of insurance companies and their relationship with medical facilities. The paper was sent out to the health care management organs of different levels in the Novosibirsk oblast, to insurance companies, medical facilities, mandatory medical insurance fund. The basic idea of the document was:

*The Main Measures on the Medical Care
Quality Assurance at the Interdepartmental
Level.*

1. The basis for interdepartmental quality assurance is the license and accreditation commission which, with the help of expert physicians, physicians' associations and outside experts, shall be engaged in consideration, modification and re-consideration of the standards of medical facilities structure, processes of providing medical care and treatment outcomes for various diseases, traumas and other pathological conditions.
2. Licensing of a medical facility shall occur 1 or 2 times a year and is finalized with issuing a license for certain medical practices.
3. The licensing and accreditation commission shall perform a continuous audit of compliance with the structure, processes and outcomes standards.
4. On presentations made by insurance companies, the licensing and accreditation commission requires a medical facility, on the basis of the claims, to supply the medical records, additional information, necessary for consideration; it also carries out the expertise of the documents including field studies made by its expert physicians.
 - 4.1 The expert physicians activity is legally restricted although a medical facility is authorized to attract the opponents, including those not employed by the licensing-accreditation commission.
 - 4.2 The size of an expert physician's reimbursement is set by the an agreement

between the expert and the commission and does not depend on the number of negative records but it can be influenced by the number of expertise session and audits carried out by him/her.

4.3 An expert physician employed by the licensing-accreditation commission can make an independent decision of applying to the court.

5. The claims identified by the licensing-accreditation commission are not accompanied by monetary fines imposed on a medical facility, however they can result in:

5.1 Removal of the license for practicing within the network of the medical insurance system;

5.2 Limitation of the number of kinds of medical practices;

5.4 Introduction of the name of a specific physician into the "black list" of the data base of the commission.

II. Organization of interaction between medical facilities and insurance companies under mandatory medical insurance system. The control functions should be minimized with the provision by medical insurance companies of the extended possibilities for additional budgeting of certain kinds of medical facilities' activity.

*Measures to Achieve Quality Assurance
in the Interaction of Medical Facilities
with Medical Insurance Companies.*

1. Insurance companies have no access to the standards of structure, process and medical care outcomes.

2. Insurance companies regularly monitor medical facilities for availability of a license or a certificate.

3. Insurance companies expertise of medical facilities includes:

3.1 work of the agents without special medical training who carry out:

3.1.1 questioning of 5-25% of patients discharged from a hospital or after treatment in an outpatient facility;

3.1.2 communicating the questionnaires with the identified claims of patients or their relatives to the licensing - accreditation commission;

3.1.3 compliance with the standard hospital length of stay of patients;

3.1.5 compliance with the standard conditions and level of service in a medical facility.

4. In case the claims related to item 3.1.4 are identified, medical insurance organizations shall get involved in running the medical facility, providing for additional financial support in order to improve accommodations, nutrition and other services.

5. Medical insurance organization are not authorized to impose financial sanctions on medical facilities.

The document caused a considerable emotional response: positive - among the administration and medical personnel of medical facilities, and negative - among the administration of the MMIF and insurance companies. As we found out later, the latter group had held a closed discussion of the document with the development of the joint counter-action plan, in case the paper should turn into the basis for an instructive letter or an order. As a matter of fact, the similar reaction followed at the conference devoted to quality management in December 1995. Later on, discussing the reaction with Dr. S. Tillinghast, he said: "I cannot understand why should they

put so much stress on the issue of quality control. Quality cannot result from control only”.

Indeed, while studying the records of the MMIF and listening to speakers at the conferences devoted to QM, general misunderstanding with the replacement of terms “quality management”, “quality assurance” with “quality control” becomes evident. Actually their relationship can be presented as a following diagram:

Quality management

quality assurance

quality control

It is worth noting that the issue of independent medical expertise was successfully worked out half a year later at the sitting of the health care department council and did not cause any heated arguments. It was probably due to the realization of the basic components of the quality problem, which may be regarded as a confirmation that we have achieved the results we were aiming at. Recently there have practically been no conflicts between the experts and the physicians of medical facilities.

Alongside with the above activities, Dr. Irina Nagornaya from the Municipal hospital N 1, has been working at the introduction of the QM theory into practical operation of the hospital, organization of the medical care process and domestic services management. Having transformed the former hospitalization unit and involving medical nurses in the process, she has managed to settle the problems formerly considered as insoluble: arranging meals delivery to the main hospital building, preventing visitors from passing through the admission room, improving the interior of the hospital corridors and admission rooms. Moreover she had started to introduce the hospital formulary before an appropriate order was issued by the oblast health care department. The detailed information on this work is included in her report.

The work related to the rational pharmacy management started with a 12-day workshop held in Moscow in April 1996 where two of our experts participated: a representative of the oblast clinical hospital and the deputy chairman of the committee on pharmacological practice (the committee is not part of the health care system structure, however it is involved in the management of pharmacy network, all the hospitals having their own pharmacies as a hospital structural divisions. In these cases hospital supply with medications is implemented on the contractual basis). The workshop materials brought by the experts were multiplied and communicated to medical facilities. In May 1996 we held a conference based on the workshop materials for the head physicians of the rural districts and hospitals of Novosibirsk. In May the order of the oblast health care department on the introduction of the hospital formulary system was issued. According to this order hospital head physicians were responsible for setting up by June, 1. 1996 the formulary committees under the leadership of the deputy head physicians on medical issues with the participation of the heads of resuscitation and intensive therapy units of therapeutic and cardiologic profiles, as well as chief medical nurses. It was recommended to hold meetings of the committees once a month and to have the work at the formularies completed by September, 1. 1996.

Considering that as it is the case with any other project, the QM project has certain fixed time limits for its implementation, our task was to provide for the continuity of the activities in this direction for the years to follow. The health care system of Russia is in many respects oriented at the implementation of some

instructive documents which in most cases provide no feedback. They are decisions adopted by various boards, orders and statements issued at different levels - federal, regional (oblast), municipal and institutional. The directives issued at the regional level are subject to execution in all the medical facilities of the oblast, that is why we made a decision to consider and approve the "Statement on the system of medical care QA" and the working team members responsible for settlement of individual problems at the sitting of the health care department board - the supreme organ for problems consideration at the regional level. The employees of the Abt Associates, Inc. office in Novosibirsk were present at the sitting, including Dr. S. Tillinghst. The text of the "Statement" approved by the board decision is given below:

Statement on the System of Medical Care Quality Assurance

The statement on medical care QA (hereinafter named "Statement") is based on the advanced experience of the health care system management in the USA and in the RF and is directed at the continuous involvement of all the oblast medical personnel in the organization of the medical and diagnostic process with the aim of meeting all the needs of the community in medical assistance. The developments made by Drs. Deming and Juran and adapted to the local conditions in the framework of the Russian-American intergovernmental agreement on the Zdravreform project, were used as a theoretical basis for the Statement. In the course of developing the Statement we allowed for a long-term lack of financing of the health care system and the task of medical care improvement under the budget deficit. Besides, we also provided for the specific features of the medical insurance model, typical of the Novosibirsk oblast. In case the medical community is ready to work in the direction of CQI, the Statement can be reconsidered and extended. In compliance with the priority problems facing the oblast health care system, the problem of quality assurance includes the following components:

1. Organization of independent expert assessment of the medical care quality.

The independent expert assessment (expertise) is carried out by the experts of the licensing and accreditation commission, whose names are identified on the basis of the agreement between the licensing and accreditation commission, oblast health care department and MMIF. The medical insurance companies make an order for performing an expert assessment in keeping with the regulations about mandatory health insurance currently in use. Besides, the medical insurance companies study the level of satisfaction of the insured by the medical care provided in the facility (polling, questionnaires for the patients, etc.).

2. Introduction of the QM system in the day-to-day work of medical facilities.

The practical experience of the QM theory application accumulated by Municipal hospital N 1 needs dissemination over the oblast territory. It can be done in the form of seminars and experience exchange workshops, compiling recommendations for medical facilities administration with specific examples of settling various problems.

3. Nosocomial infections control.

The problem seems to be one of the highest on the list of priorities for the health care systems of both highly developed countries and the Novosibirsk oblast. The preliminary study of the problem demonstrated that the principal ways of its settlement are: establishing information supply on the basis of one of the oblast hospitals, institutional measures for preventing nosocomial infections which do not require large financial investments, rational use of anti-bacterial preparations and reconsidering the general concept of the sanitary-epidemiological hospital regime.

4. Rational pharmaceuticals management.

It is one of the most acute problems under the budget financing deficit. In the hospitals of the highly developed countries it is regulated through the hospital formulary system. The method first started to be introduced in the Ryasan oblast clinical hospital. We have carried out some preliminary work on the formulary introduction on the territory of the Novosibirsk oblast. The problem needs further development due the inadequacy of the initial level of knowledge of practitioners in the field of clinical pharmacology and pharmacokinetics. There are infinite possibilities of estimation of the medications costs of the oblast medical facilities and budget investment savings (on article 10).

5. Reduction of the patients length of stay in a hospital for some dangerous and frequently occurring diseases.

Certain development related to one of the pathological states - myocardial infarction - has already been carried out by the cardiologists of the Kemerovo oblast. The work resulted in the reduction of the LS in a hospital from 40 to 13 days. There are similar proposals for acute pneumonia, virus hepatitis and a number of other diseases. The hospital care costs are going down with retaining and even improvement of the quality assurance standard.

6. Development of the capitation budgeting principle.

The work is being carried out within the framework of the grant received by the Cherepanovo central district hospital from the Abt Associates, Inc. company. After the experience is sufficiently accumulated and studied, it can be disseminated throughout the oblast.

7. Development of the medical technologies standards and algorithms for medical care provision.

There are approbated foreign developments applicable for local utilization if adjusted to the regional peculiarities. Further development and introduction of the new statistical data is required - "quality indicators" for the objective assessment of the innovations' efficiency.

Forms of Work on Quality Management

Annually the oblast health care department board appoint a leader of the working team for each field of activity and identify the coordinator for the whole scope of work with regard to the newly set objectives.

Once a year a working team of each direction reports to a meeting held at the oblast health care department, once a year a general report of all the teams is compiled and presented for the board approval after which it is communicated to other medical facilities.

After the reports have been considered and approved, the materials are institutionalized in the form of orders (including those made up jointly with the pharmaceutical committee, oblast state sanitary and epidemiological supervision center, etc.), information letters, practical recommendations, etc.

Working teams, health care administration and medical personnel can appeal to the board about introduction of additional projects and amendment of the tasks and objectives for the next year submitting a written application to the board address.

Team leaders have the right to engage the medical personnel in the implementation of the set tasks and objectives at their own discretion. The project coordinator is responsible for approval of the candidates for the positions by the leaders of departments, committees, institutions, services, etc.

Working Team Leaders for the year of 1996

The partner from the Russian-American "Zdravreform" project -

Dr. Stanley Tillinghast;

The QA project coordinator - deputy head of the oblast health care department - M.N. Melnikov;

Working team leader on organization of independent expertise of medical care quality - chairman of the licensing and accreditation committee L.F. Selivanova;

Working team leader on introduction of quality management in the work of medical facilities - deputy head physician of Municipal hospital N 1, I.N. Nagornaya;

Working team leader on nosocomial infections control - deputy director of the Research Institute for regional pathology and morphology (Siberian branch of the Academy of Sciences of the RF), prof. E.F. Bocharov;

Working team leader on rational pharmaceuticals management - deputy head of the oblast health care department, M.N. Melnikov;

Working team leader on the problem of reduction of the hospital length of stay for the most frequent and dangerous diseases - chief therapist of the oblast health care department, A.V. Tereschenko;

Working team leader on development of the capitation budgeting principle in Cherepanovo district - district head physician, Yu. B. Kim;

Working team leader on development of the standards for medical technology and medical care algorithm - chief therapist of the oblast health care department, A.V. Tereschenko.

The coordinator and the working team leaders are personally responsible for the their spheres of activity during the year, for drawing up reports and institutionalization of the accumulated materials.

The health care leaders of various levels shall provide all the information necessary for the activities of the working teams in quality assurance. They shall not prevent implementation of the measures restricted by various practical recommendations and other documents, even if they go counter their personal convictions.

Based on the discussion the health care department board adopted the following decision:

**Decision N 11
of the board as of April, 24. 1996 on the issue of approval of the
“Statement on the System of Medical Care Quality Assurance”**

Having heard and discussed the report made by the deputy head of the oblast health care department, Mr. Melnikov M.N., the board has adopted the following decision:

1. To approve the Statement on the system of medical care quality assurance.
2. The chairman of the licensing and accreditation committee at the Novosibirsk oblast administration, Mrs. Slivanova L.F., should prepare by June, 1. 1996 the list of expert physicians approved by the oblast health care department and the MMI fund.
3. The deputy head physician of Municipal hospital N 1, Mrs. Nagornaya I.N., should organize a 2-day seminar for deputy head physicians and chief nurses of medical facilities. Before August, 31. 1996 the practical recommendations on organization of the QA process in a medical facility should be worked out.
4. The deputy director of the Research Institute for the regional pathology and morphology of the Siberian branch of the Academy of Sciences of the RF, Mr. Bocharov B.F., should be asked to study, together with the head physician of the regional center for state sanitary-epidemiological supervision, the practical experience of the Abt Associates' experts in the oblast clinical hospital and to prepare, on behalf

of the oblast health care department, an order on prevention of nosocomial infections.

5. The deputy head of the oblast health care department, Mr. Melnikov M.N., should prepare, before June, 1. 1996, the order on introduction of the hospital formulary system into the practice of medical facilities.

6. The chief therapist of the oblast health care department should submit his proposals on the reduction of the hospital length of stay for the patients with myocardial infarction.

7. The function of control over the implementation of the decision is assigned to the deputy head of the health care department, Mr. Rogov V.N.

The significance of the decision is related to the fact that the board decisions are normally subject to a rigid control system and the results are to be reported a year later at one of the board sittings.

Out of all the problems worked out within the framework of the Russian-American agreement, the most problematic was the one associated with the implementation of the Cherepanovo project of the health care system financial reform. In my opinion this project started to attract some interest after the Zdravreform project representatives were provided with the information of the possible World Bank investments in the renovation of the Cherepanovo hospital. In all probability, the decision of implementing the reform of the budget management system in relation to the district (rayon) health care system, was taken considering the new potential opening up for the central hospital after its renovation and technological reequipment. Basically this problem has a very slight connection with the medical care quality management, although it is extremely important both for the Novosibirsk oblast health care system and the whole of the Russian Federation, since it may result in restructuring of the health care system and is a key issue for realization of any reform. With regard to the experience accumulated in other territories which have already succeeded in adopting the capitation rate in health care budgeting (Saint-Petersburg and Kemerovo oblast), introduction of the new financing principles does not only lower the costs but also helps in putting more stress on outpatient care and general practice development. It provides for the reduction of the hospital length of stay and promotes restructuring of the bed fund with its further decrease, etc. That is why our interest towards Cherepanovo project is so great.

Initially, at the stage of the project development and grant reception, we felt completely assured that the project will be implemented and will get a full advisory and methodological support of the American party. Quite by chance, in March 1996 I met the Cherepanovo hospital head physician who shared his doubts about the project implementation. In April I visited the Cherepanovo hospital and met with the working group there, they proved completely unable to solve the set task. The hospital personnel working with Dr. Yu. Kim seem to be fully aware of their responsibility, they had made a number of business trips to learn about the basic working principles based on the methodological recommendations submitted by Dr. Telyukov. However they lacked adequate theoretical knowledge about the problem, besides, the district was not provided with the Windows and Excel programs for their computers which would enable them to work on the diskettes with the materials provided by the Tomsk oblast clinical hospital. In order to solve the problem, after approval by Mr. A. Bychkov, head of the oblast health care department, a group of experts from the planning-financial department and the

information- computer center was forwarded to the district hospital. The group had made two trips bringing a Notebook type computer with them provided with the necessary software. Elena Ignatenko, a specialist specifically trained in the field of health care system budgeting in a Great Britain tour organized in the framework of the Zdravreform project, was among the group members. In the course of the field work additional materials were developed, wherefore the economist V. Voronyuk with the participation of the programmer, R. Edokov from Novosibirsk, prepared the materials necessary for the presentation of the first report to the USAID in the name of Mr. Langenbrunner.

It seemed that the problems started to get solved. However it happened so that Elena Ignatyuk had to leave the health care department and find another job. Because there was no other expert capable of solving the problem of development of the capitation rate budgeting, I had to apply to Dr. S. Tillinghast requesting him to attract the personnel of S.-Petersburg mayorate to settle the problem. We had received their consent but at the time the staff shifts started in the city administration which was related to the results of the mayor's elections in S.-Petersburg which brought Mr. Yakovlev to power. This caused changes in the departments' staff members, including the health care committee, which dissipated our hopes of getting their support. At the moment we are placing our hopes of the work completion on the visit to Mr. Edward Frid from Kemerovo who promised his assistance. The trip is scheduled for August, 14. 1996. Mr. Frid gave his consent to go out to Cherepanovo district to be introduced the current situation right on the site, however we are ready to take out all the necessary material to Kemerovo.

Probably it would have been much easier if I knew the methods of health care budgeting in other countries, however, being the deputy head of the oblast health care department on medical issues, I am more aware of the problems of medical care quality management and assurance rather than estimations and methods of uniting various financing sources: budget and mandatory medical insurance. At the same time it is absolutely obvious that only having reformed the health care financing system, we could achieve the objectives set earlier in our instructive documents: medical care accessibility, development of primary medical and sanitary care based on the principle of general practice services, putting more stress on the outpatient care, development of preventive and family medicine, reduction of the bed fund, improvement of the bed turn over rate, structuring of the bed network, bed differentiation depending on the intensity of their utilization, etc. I introduced the new deputy head of the oblast administration supervising health care and social policy issues, Mrs. Nadezhda Nazarova, to the proposed variants of the reforms and their possible aftereffects. She demonstrated a complete understanding of the problems and gave her preliminary consent for carrying out the experiment of uniting the finances of the budget and the mandatory medical insurance in 1 or 2 districts of the oblast. In case of the positive result, staged dissemination of the experience over the oblast could be possible.

Besides, it is necessary to point out that the MMI fund is now working at the development of its own variant of the budget estimation base on the capitation rate. What is it going to be like? The experts of the health care department have already studied the experience of this kind of estimation made by the Asopo-Zhizn insurance company. Is it going to be the estimation technique, consisting of just 5 items of budgeting against the age structure of the community, or any other substitutes? Or will it be solution of the narrow departmental problems aimed at today only? We have got no answers to these questions so far. What is obvious about today's health care problems - is lack of the personnel capable to adequately solve the problems of

planning financial management of the medical branch, to have a perspective vision and to take well grounded decisions. One of the requirements towards the reporting procedure was to give a coverage of the political problems while working out solutions for the quality management issues. In my opinion there are no such problems. The problem is fairly apolitical. I happened to witness the process of replacement of all the administration staff of the Novosibirsk oblast, starting with the head of administration and ending with the regular heads of departments and committees. In the meantime, in the course of discussing quality management issues, I did not meet with any resistance on their part to the positive reforms, as long as they prove appropriate and forced by the actual needs. Even the issues related to financing business trips of our experts under the present conditions of the acute budget deficit, found prompt and easy solution. However there was a completely different psycho-emotional perception of the problem. I would like to demonstrate it with only one example of the statement made by one of the head physicians of the district (rayon). In the course of the first briefing on hospital formularies, my colleague, head of department, who was sitting among other head physicians had to witness the following talk: "Look, what they have thought up again, they just won't let us leave in peace and quiet." This is not surprising, since the hospital formulary system is closely connected with their vital interests. It is no secret that the socialistic system of distribution of pharmaceuticals and diagnostic and medical distribution is still perceived by head physicians of medical facilities (especially in the rural districts), as positive one, the best in the world. They tend to ignore the role of a physician - the medical service provider; they forget about his level of life, his ability to provide qualified medical care and his competitiveness at the service market. There still are a lot of medical facility administrators who believe in the slogan: a physician owes to a head physician; instead of adopting the reverse version: head physician (administrator) owes to a practical physician, he needs to take care of his needs and concerns in order to attract as many patients to the facility as possible.

All the medical personnel involved in the process of providing medical care can adequately comprehend the set tasks and objectives only if all the participants of the process are financially motivated and are capable of withstanding the interdepartmental competition in their fight for a patient and the quality of medical service.

Drawing a conclusion of this preliminary report, I can make the following statements:

1. The problem of medical care quality management is critical for the health care system of Novosibirsk oblast and presently it is well realized by the majority of the medical personnel.
2. The work started in the direction of the quality management has already resulted in some success and needs to be continued and extended.
3. It is necessary to make further efforts directed at achievement of the irreversible character of the reforms, irrespective of the work performed by some individuals and facilities.