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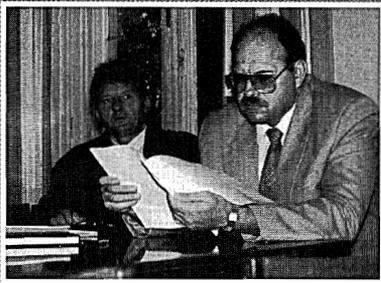


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# Vital

the  
ZdravReform Program

Issue 2, Fall 1995

Checking the pulse of health reform in the NIS

# Signs

## Reinverting the Pyramid: Reforming Primary Care in NIS Health Systems

By Michael Borowitz, M.D., MPH, PhD., Regional Director for Central Asia

The health systems in the New Independent States (NIS) are in crisis. The factors that precipitated this crisis were the break-up of the Soviet Union and the economic crisis that ensued in moving from a planned to a market economy. In recent years, significant decline in the gross domestic product (GDP) of all of the countries of the NIS has meant that less funds are available to support a generous welfare state. In the health sector, funding has decreased from approximately 6 percent to 3 percent of GDP. The decline in funding has made apparent the profound inefficiencies in the health systems inherited from the Soviet Union.

The most profound inefficiency is the imbalance between the hospital and primary care sectors. The health systems in the NIS can be likened to an inverted pyramid: most of the resources go to the hospital sector and to polyclinics, with only limited funding available to the primary care sector. There are a large number of hospitals, hospital beds, and hospital personnel, which consume approximately 70 percent of health care resources. Historically, the hospital sector provided almost all of the care. Hospitals have been supported by polyclinics that staff a multitude of specialists. Conditions that could be effectively

treated in the primary care sector, such as simple pneumonia, hepatitis, angina, etc., are treated in the hospital or by specialists at polyclinics.

The central question in health reform is how to shift the provision of care and resources from an expensive and inefficient hospital sector to cost-effective primary care.

In theory, primary care was well-developed in the former Soviet Union. In urban areas, polyclinics were to provide primary care. At first glance, co-locating physicians in the polyclinic building and creating economies of scale may appear to have been a good method of organizing primary care. In practice, however, the polyclinic system has not functioned as the main provider of primary care to families.

In effect, the primary care sector is highly fragmented. Usually, there are separate polyclinics for adults, children, and women. In addition, many conditions are treated only in specialized dispensaries—such as psychiatry, dermatology, venereal diseases, tuberculosis, and oncology—and many chronic conditions, such as diabetes, are treated by specialists.

Patients are assigned to a polyclinic primary care physician based on where they live—catchment areas. The

catchment area physician, however, has a limited clinical domain, based on the factors discussed above, as well as limited training and almost no equipment. For example, a primary care pediatrician does not have an otoscope. Therefore, if a child comes in with a suspected ear infection, the primary care physician will refer the patient to an ear-nose-throat specialist.

This situation is exacerbated by the financial incentives in the system that encourage excessive referral rates. In Kazakhstan, for example, referral rates for first visits are approximately 30 percent, as compared with 8.6 percent in the United Kingdom and 5.2 percent in the United States. Primary care physicians simply fulfill norms for the number of visits. They are underpaid and have no incentive to take on more work. Because they receive the same salary even if they assume more clinical responsibilities, there is no incentive not to refer. Another factor encouraging referral is that more than half of the physicians in polyclinics are specialists. However, since polyclinics are generally underequipped and underfunded, polyclinic specialists in turn refer a large percentage of patients to hospitals, which receive the lion's share of the budget. This is one explanation for the very high rate of hospitalization in the NIS, approximately 20 percent of the population per year.

The problem in the primary care system is a combination of underfunding, lack of equipment, inadequate training, and inappropriate incentives. Reforming the primary care system requires a set of interlocking changes that will reinvert the pyramid and create a well-functioning primary care system that can treat the majority of conditions.

In an underfunded system, it is essential to concentrate resources on health care interventions that provide the maximum health gain for the least cost. The most cost-effective interventions are immunizations, well-child care, treatment of childhood diarrheal diseases, acute respiratory infections, anti-smoking activities, treatment of hypertension, and maternal care. Almost all of these interventions can and should be provided by a well-functioning primary care system. As the World Bank's World Development Report points out, redirection of resources from expensive hospital and tertiary services to

interventions such as those listed above that focus on public health and basic clinical services could potentially reduce the burden of disease dramatically without increasing overall expenditures on health. This is possible because the cost per disability-adjusted life year, or DALY, gained through primary care interventions can be as low as \$25.<sup>1</sup>

Before discussing some of the attempts to reform the primary care system in the NIS, it is important to have a better understanding of what constitutes a good primary care system. The major recognized features of primary care are first contact, longitudinality, comprehensiveness, and coordination.<sup>2</sup> Primary care is comprehensive and person-centered rather than disease- or problem-specific.

Primary care differs from secondary and tertiary care in the following ways:

- The problems that primary care physicians face are more general and less clearly defined;
- Primary care is usually provided in community-based settings;
- Most primary care interventions are to deliver preventive services; and
- Physicians maintain an ongoing, or longitudinal relationship with a high proportion of patients.

In 1978, the World Health Assembly defined an effective system of primary care as:

Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function, and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.<sup>3</sup>

<sup>1</sup>World Development Report 1993: Investing in Health, (New York: Oxford University Press, 1993): 8.

<sup>2</sup>Starfield, B.S., Primary Care: Concept, Evaluation, and Policy (New York: Oxford University Press), 1992.

<sup>3</sup>World Health Organization, Primary Health Care, Geneva, 1978.

*Continuity and Longitudinality—Key Features of an Effective Primary Care System.* Most people do not know enough about the details of medical care to make informed decisions about the most appropriate source of medical care for many of their problems. Self-referrals to specialists may be inappropriate or misguided, resulting in delay of needed care, and/or unnecessary or excessive expense. Primary care providers act as the patient's agent in navigating the health care system and as the health care system's gatekeepers. They determine whether specialty care is needed and facilitate the selection of the most appropriate source for that care.

Many problems brought to specialists by self-referred patients might have been managed equally effectively by a primary care physician, generally at a lower cost. Primary care physicians are trained to be more familiar with the early stages of illness and are thus more capable of assessing the importance of symptoms and signs at those stages. Long-term relationships with patients also make physicians more sensitive to changes.

*Family Practice—the Most Desirable Form of Primary Care.* Because most people live in families, it is beneficial to both patients and practitioners for an entire family to enroll in a practice. A relationship between a family and a particular primary care physician or physician group improves continuity and contributes to the sources of information the practitioner has about all of the relevant factors influencing an individual's health. An ongoing relationship with a family increases a physician's insight into a person's well-being and also provides a living familial medical history for younger generations treated by the same practitioner as their parents.

Family physicians can also be more convenient for families with young children or with limited time and resources to travel to appointments. Because several family members can obtain care during one visit to the physician's office or practice site, there is an increased likelihood that appointments for preventive and early intervention care will be made and kept.

#### *Single Practitioners Versus Group Practices.*

Depending on the organizational structure of the primary care system, the longitudinal relationship of the patient may be with an individual practitioner or an integrated team practicing as a group. A single practitioner who has an understanding of the entire family can provide

continuity of care. However, it is difficult for a lone physician to master all of the clinical knowledge for both pediatrics and adult medicine. A group of physicians, on the other hand, can function as a primary care group practice if they are a well-integrated team. The issue of solo general practitioners versus group practices is particularly difficult in the context of the NIS, since medical education is oriented towards training specialists. Until recently, there was no training program that produced general practitioners. Therefore, to create family practices, currently practicing, specialists must be retrained as generalists.

*Experiments with Primary Care in the NIS.* During Perestroika, there came an awareness that the health care system was too dominated by hospitals, and the polyclinic system was too specialized. Under the New Economic Mechanism, there were attempts to remedy these problems by creating primary care group practices. These practices consisted of an internist, a pediatrician, and a gynecologist, known by the Russian acronym APTK. APTKs were an attempt to create a primary care unit that could provide care to an entire family; however, in practice their success was limited for several reasons. First, the polyclinic assigned physicians to work together and form an APTK. Often, their offices were not located in contiguous space. In some cases, the APTK consisted of physicians working in different polyclinics or on different floors. The groups did not form a cohesive unit, nor did they share workloads or cover each other's patients. Second, the method for reimbursing the groups was not significantly changed. There was almost no incentive to improve efficiency and provide care and thus decrease referrals. Third, the groups did not receive the core equipment needed to decrease referrals. Fourth, the groups received no additional training, including the cross-training necessary for them to develop into general practitioners. Finally, patients were assigned to APTKs, just as they had been assigned to physicians in the polyclinic. From both the patients' and physicians' perspectives, the APTK was little more than a new name for the old system.

As with APTKs, other attempts to create family practitioners have been unsuccessful. In many cases, family practices have been given an office in a neighborhood. Usually, these practices are satellite clinics of the polyclinic. Physicians are assigned to work in these clinic, which are often far from where they live. They are

paid on salary and have little incentive to increase their levels of clinical activities.

Although these practices have been somewhat successful in moving health care closer to the population, the overall effect on the health system has been limited. In the absence of a reimbursement system that rewards physicians for improving their practice, they have little incentive to decrease referrals. Furthermore, these experiments have been hampered by limited training and equipment. Polyclinics remain the main organizational unit that provides primary care.

*ZdravReform Approaches to Reforming Primary Care in the NIS.* The *ZdravReform* Program is taking different approaches toward reforming and strengthening primary care systems in order to improve health and achieve cost savings in the NIS health sectors. The most comprehensive primary care sector reform is occurring in the Issyk-kul Oblast Intensive Demonstration Site in Kyrgyzstan. (For other *ZdravReform* approaches to restructuring the primary care sector, see box on pages 10 and 11.) Under a new system of primary care fundholding, primary care is provided by

small groups of primary care providers. These providers are paid by capitation and hold funds to purchase outpatient and hospital care needed by their patients.

The first step in the process is for physicians to form independent Family Group Practices (FGPs). The Family Group Practice Association, which meets regularly to discuss topical issues in primary care, is facilitating the formation of these groups. Already, 16 FGPs have been established, and 16 more are being formed. Eventually, 100 groups, which will become the exclusive providers of primary care in the oblast, will be formed. Polyclinics will no longer exist. Many of the groups will be located outside the polyclinics. In some cases, polyclinics will be reorganized into Family Group Practice Centers. Each of the groups will have its own contiguous space with a sign to create its own identity. In rural rayons, small rural hospitals (SUBS) and rural clinics (SVAs) are being converted to FGPs.

Each group practice consists of at least two physicians (a pediatrician and an internist), two nurses, and a practice manager. In some cases, the practices will be larger. The groups are being provided with basic equipment such as stethoscopes, blood pressure cuffs, otoscopes, and scales. A clinical training course has been set up to teach the physicians how to use the new equipment and how to manage basic medical conditions in an outpatient setting. Each group will enroll 1,000-1,500 patients per physician. Enrollment in the practices is voluntary, and a public information/marketing campaign has been developed to educate consumers and encourage them to enroll in FGPs.

FGPs will serve as fundholders for all outpatient services and inpatient care. They will

**Continued on page 10**

Increased physician-patient contact is one of the positive side-effects of the organization of family practices.



# ZdravReform Grants Help Spur Development

by Alexander Mkervali, Information Dissemination Specialist, Moscow office

Russia's health sector, with its inefficient allocation of resources and lack of incentives for health professionals, has been in decline for some time. Through its Moscow office, the ZdravReform Program is attempting to improve this situation.

ZdravReform's past four months in Russia have proved to be very successful, and exemplify what the Program is all about. With the conclusion of two grant competitions in July and August, the number of grants the Program provides to Russian health reform innovators has grown to 37 to encompass such important areas as maternal/child health, health management training, and medical professional association activities.

The first of ZdravReform's two summer grants competitions was the Healthy Communities competition, for which the Moscow office received 27 applications. After a thorough review of applications, grants of US\$99,000 each to the cities of Izhevsk, Kostroma, and Lipetsk were awarded. The first two cities will use the funds to concentrate on maternal/child health, while Lipetsk will use its award to devise a new immunization program.

The second competition, the Health Sector Leadership Development competition, attracted 56 applicants from across Russia. The goal of the competition was to identify and encourage organizations to promote leadership in the health care sector, primarily through setting up professional associations, publishing new journals and newsletters, and improving managerial standards. ZdravReform used a two-round evaluation scheme to identify organizations worthy of being awarded these grants. Sixteen winners were selected from around the country, from Rostov-on-Don in the South to Khabarovsk in the Northeast. The recipients received a total of US\$857,550, ranging from US\$25,000 to US\$80,000 each.

of

Follow-up monitoring shows that grantees that began work earlier in the year are living up to ZdravReform's expectations. Of particular note are recent successes: public service announcements have been broadcast in St. Petersburg; general practices have opened in Novosibirsk; and an HMO is being developed in Tula. In addition, a new alcoholic treatment center based on the Alcoholics Anonymous program is thriving in the Volga-area city of Nizhny Novgorod.

Faithful to its commitment, ZdravReform continues to work with its Russian grantees, providing them with financial and technical support they may need to ensure their further success.

## Russia's Health Sector

## ZdravReform/World Bank Collaboration

In October 1995, ZdravReform signed letters of agreement with the Territorial Funds of Tver and Kaluga Oblasts to collaborate in the design and implementation of a series of pilot demonstration projects (working models). In Tver, ZdravReform will establish pilot demonstrations in five sites to test the following reforms:

- Incentive-based payment systems based on capitation,
- Improved, standardized management information systems (MIS) with cost accounting, financial modeling, and financial management, and
- Continuous quality improvement (CQI) methods and approaches.

In Kaluga, ZdravReform will establish the following pilot demonstrations at six hospitals and polyclinics, as well as the health committees and Territorial Fund in the oblast:

- Integration of financial flows, currently controlled by health committees and the Territorial Fund,
- Incentive-based payment systems based upon capitation, primary provider (partial) fundholding, and global budgeting,
- Improved, standardized MIS with cost accounting,



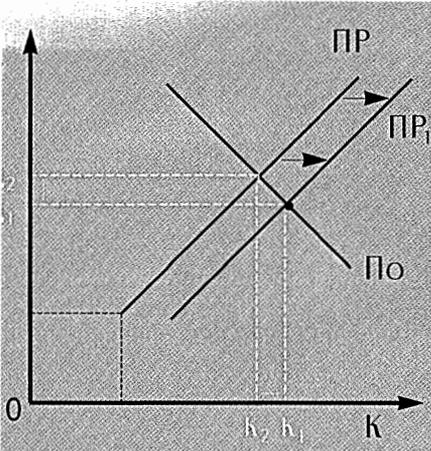
- financial modeling, and financial management, and
- CQI methods and approaches.

ZdravReform will provide technical assistance, training, and software to design, implement, and evaluate these working models over the next year. Once pilot testing is complete in both oblasts, the World Bank is planning to provide \$85 million to support the full implementation of these and other pilots to 80 institutions in Tver and a like number in Kaluga. For an investment of approximately \$1.2 million, ZdravReform will assist in the implementation of reforms that will ultimately improve the delivery of health care to a population of 4.5 million persons and provide reform models to be emulated throughout the region.

**ZdravReform signs letters of agreement with Territorial Funds of Tver and Kaluga Oblasts in Central Russia.**



# Health Economics and Payment Methods Courses Are a Hit in Ukraine



In late September and early October, the ZdravReform Program conducted health economics and payment methods training courses for health sector professionals in Kiev, L'viv, and Odessa, Ukraine. The courses were designed to provide the 70 participants with new information and techniques to assist them in their efforts to reform Ukraine's health care system.

Turnout for the courses was good, and participants expressed overwhelmingly favorable reactions. According to one participant, the sessions "opened doors into a whole new world."

Four senior health economists from Abt Associates' Bethesda office taught the courses. Economists Marty Makinen (Abt Associates Vice President and ZdravReform Technical Deputy) and Abdo Yazbeck taught the week-long microeconomics course in all three locations. In Odessa, economists Gary Gaumer (Abt Associates Vice President) and Annemarie Wouters (formerly acting L'viv IDS Manager) followed the economics course with a week on provider payment methods.

The ZdravReform-developed microeconomics curriculum covers supply and demand analysis, producer costs and decision making, market structure, cost-effectiveness analysis, and the economics of health insurance. The payment methods materials include sections on definition of terms, global budgeting, capitation, and case-mix adjusted payment. Some additional topics of local interest were covered at each of the three course locations.

The course instructors made liberal use of "Western" teaching techniques, including the use of overheads and flip charts, role playing, and group work

on problems using analytical methods. The course format encouraged active participation by attendees and included many practical exercises. Many of the participants had not previously been exposed to these techniques, but found them conducive to learning.

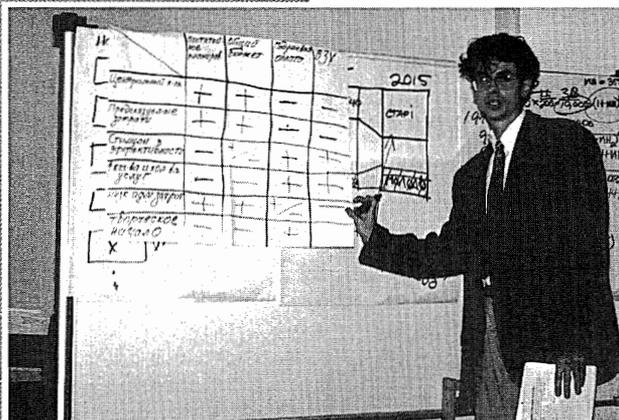
Course participants included chief doctors and economists (financial analysts) from hospitals and polyclinics (especially, but not exclusively, from ZdravReform pilot facilities); representatives of oblast, municipal, and rayon health authorities; faculty members from schools and universities (who were also trained to teach the course in the future); and others. Notably, Dr. Ivan Furtak of L'viv Medical University and Dr. Oleg Kungurtsev of the School of Health Administration in Kiev participated in both the Odessa and Kiev sessions. Five rayon chief doctors from Moldova also attended the Odessa sessions.

Several participants who initially indicated that their regular duties would prevent them from attending more than the introductory and concluding sessions of the course attended all of the presentations. In some cases, they required their staff to do the same. Among those who made more time for the courses included Dr. Nikolay Ivanov, Head, Odessa Municipal Health Department; Dr. Valentina Bespoyasnaya, Director, International Family Health Center in Odessa; Dr. Jemma Jafarova, Chief Doctor, L'viv City Hospital Number One; and Dr. Ivan Solonenko, Director, Kiev School of Health Administration.

Overall, participants rated the courses highly in their evaluations. Many participants responded favorably to the instructors and their degree of professionalism, the course content and organization, the availability of training materials (which were prepared in both Russian and Ukrainian and contained the main points of the course lectures, as well as readings, problem sets, and examples). A number of participants in the microeconomics course asked whether the course could be repeated for additional audiences. Suggestions for improvement included: making the courses longer, going into greater depth on topics, and increasing the use of examples from Moldova and Ukraine.

Additional training planned for later this year and early next year include courses on health insurance, to be held this December in Kiev; management, to take place early next year in Moldova and L'viv; and cost accounting and financial management, currently scheduled for early 1996 in Odessa and L'viv.

**All courses included a focus on the training of trainers. In this photo, a Kiev School of Health Administration student presents to the group.**



# L'viv IDS Team Begins Work

By the L'viv IDS Office Staff

The *ZdravReform* Program's intensive demonstration site (IDS) office in L'viv, Ukraine, officially opened in September 1995. Amid the emerging colors of fall that surrounded the city's graceful monuments and buildings, the timing seemed perfect for all the components of success to converge. Just one month before, the L'viv Oblast Health Administration had signed a letter of understanding with USAID, reflecting a commitment to *ZdravReform* that the administration had expressed throughout the year. Meanwhile, the head doctors of the four pilot facilities were displaying their sense of leadership and budget consciousness by reducing the number of hospital beds in the facilities, curbing the number of patient days, and opening primary care clinics. Additionally, the L'viv IDS team had been completed with the appointment of a new site manager and an office manager.

Many capable people with multiple talents, skills, and interests make up the L'viv IDS team—individuals who, most fortunately, complement and support each other in working to achieve group goals. This multispecialty team serves as a model of productivity, creativity, and quality support for our Ukrainian counterparts.

Two interpreters, Rouslan Horbluik and Victor Tyushka, compose the nucleus of the IDS communication unit. Horbluik and Tyushka, who are fifth-year English students at L'viv University, are known as the team's "rollout ramblers" because of their extensive database of modern music, computer games, and local "watering holes." In addition to interpreting and translating in English, Ukrainian, Russian, and Polish, they facilitate communications with our counterparts in many other ways. For one, they enhance counterparts' accuracy by gaining an understanding of medical and economic concepts as they translate. In addition, Horbluik and Tyushka reconstruct spreadsheets and create graphics using our new portable scanner. (See photo, page 8—The scanner can also be used in the field, to transmit documents to our office database by e-mail, facsimile, or diskette from the financial journals of the pilot facilities, which have no copying capabilities.) The two interpreters are also adapting our CD-ROM



recorder to include an educational disk file for medical and paramedical professionals. Initial disks will be taken from Kevin Woodard's electronic library produced under ZRP/Russia. The library features 676 translated documents.

The master architect of the CD-ROM continuing education curriculum is Dr. Boris Uspensky, medical director. Uspensky serves as quality control officer for our interpreters in Ukrainian, Russian, and Polish. Although he serves on the team full-time, Uspensky keeps his medical specialty skills current by maintaining a night duty schedule in obstetrical anesthesiology. Uspensky claims he gets his greatest inspirations for *ZdravReform* while waiting for the next delivery in the quiet hours of the early morning. As a successful physician, Uspensky has gained the respect of L'viv's medical, business, educational, cultural, and political communities. He is an asset to *ZdravReform's* credibility and acceptance in L'viv.

The most recent addition to the team is Office Manager Victoria Mouzytchuk. In addition to her experience in office management, Mouzytchuk is a certified tour guide for the city of L'viv and has assembled a booklet for visitors to our site. She makes all the arrangements for visiting technical advisors and officials, and provides tours and makes reservations for the many cultural events L'viv has to offer. In addition, Mouzytchuk serves as a backup Ukrainian interpreter/translator for the communication unit when its workload peaks.

Secretary Olga Samoylenko is a third-year English student at L'viv University. She is proficient in all aspects of telecommunications, including e-mail, facsimile, word and data processing, and, most importantly, making connections through Ukraine's telephone lines.

Samoylenko organizes the reports, publications, and electronic files by IDS task numbers and country of origin to facilitate quick reference and retrieval from our rapidly growing office library. She also serves as a backup Ukrainian interpreter/translator.

Another versatile member of the L'viv team is our driver, Andriy Artym, who offers safe, reliable, and punctual transportation upon demand. He also serves as our electrical, mechanical, and electronic engineer. Artym has mastered the copying and collating machine and all its idiosyncrasies, which has contributed significantly to the staff's productivity and sanity.

IDS Manager, John Stevens, has been challenged to maintain the pace and enthusiasm that our dynamic team has created. This past summer, Annemarie Wouters, a senior health economist in Abt Associates' Bethesda, Maryland, office, did an excellent job preparing Stevens for his duties in L'viv. With his extensive background in hospital administration and, in recent years, managed care programs, Stevens contributes a cohesive but versatile leadership style that has accelerated staff momentum and focused the team's energy on the four L'viv IDS outputs listed below.

Currently, the L'viv IDS team is working on the following four outputs:

**Output 1**—Reform of a rayonwide primary care delivery system in Skole Rayon, which currently operates five primary care clinics. The rayon plans to open eight more clinics and include family medicine physicians among their staff. L'viv Polyclinic No. 2 and L'viv City Hospital No. 1 already have family medicine clinics and will share their experience with Skole Rayon Central Hospital. Additionally, Zhovkva Rayon Central Hospital has more than 40 years' experience using feldshers in community primary care centers and will contribute its knowledge and

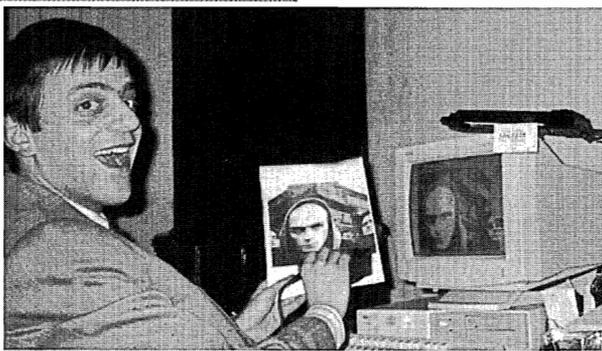
experience to the "best practice" pool of knowledge surrounding primary care practice.

**Output 2**—Restructuring of a rayonwide hospital/polyclinic system in Zhovkva Rayon, which has reduced its bed complement from 920 to 725 in the past two years. (The rayon closed one 40-bed specialty hospital in advance of any supporting national legislation that offers economic incentives to do so.) With the appropriate regulatory environment, the Zhovkva Health Administration is ready to consolidate many services and shift the emphasis to primary care throughout the rayon. The major deterrents to such a shift are the lack of clarification regarding regulations and financial incentives, and penalties for further restructuring. *ZdravReform* will continue to assist Zhovkva in a combined effort with the other three pilot facilities. Together with the other pilot facilities, we will work with the L'viv Oblast Health Administration to clarify the Zhovkva Health Administration's current authority to implement reforms. In addition, we will assist in developing new payment methods that foster sustainable reform in the future.

**Outputs 3 and 4**—Complete overhaul of the payment and management systems of two prototype health facilities: L'viv City Hospital No. 1 and L'viv Polyclinic No. 2. These two facilities are experimenting with separate systems that will benefit each other through a mid-development rollout process. City Hospital No. 1 has implemented a salary incentive program for clinical teams, while Polyclinic No. 2 is preparing to form a facility-based private practice group of surgeons that will provide publicly financed medical care to a defined rayon population.

Another management tool that will be applicable to both hospitals and polyclinics is patient care "pathways," or clinical protocols. Stevens is working in tandem with visiting technical advisors in financial management to develop a multipurpose output that can be used to analyze clinical staff utilization of resources, quality improvement, and educational needs. This particular activity serves as a good example of the L'viv IDS team's approach: developing its outputs and then maximizing their impacts by sharing results with all pilot facilities. By learning and practicing these techniques, NIS counterparts will develop the independence necessary to sustain health reform long after the departure of the *ZdravReform* team. 🌐

**Victor Tyushka reproduces graphics and photos using a portable scanner.**



IDS OUTPUTS



# The Translation Process under the ZdravReform Program Presents Many Challenges

By Svetlana Tumanova, Russia Backstop, Bethesda Office

The translation and interpretation professions have always served to mitigate misunderstandings between cultures and among people who need to communicate in different languages. On the ZdravReform Program (ZRP), translators and interpreters fill this valuable role while facing additional challenges of managing an extremely high volume of highly technical, quick-turnaround translations.

Translator/interpreter coordinators in ZdravReform's field offices have been working to streamline and improve the translations process and the means of disseminating translated information. A system for managing the flow and tracking the completion of translations has been put in place in all field offices, and is coordinated at ZRP headquarters in Bethesda. Each month, translations lists are sent to Bethesda, and there is an exchange of these lists among offices. ZdravReform staff and counterparts can request copies of translations through the coordinator in the office that lists the translated material as being available. Most of the lists are available electronically, as are many of the translations. All offices maintain a numbering system, and some offices maintain databases of available documents.

While the system solves many issues in organization and distribution, some difficulties remain in producing translations. For example, in Kiev, Ukraine, the demand for documents in both Russian and Ukrainian requires more time and resources. According to Lena

Truhan, Office Manager in Kiev, Ukraine, the majority of government officials and those who live in western Ukraine prefer materials in Ukrainian. However, the population around Odessa and in eastern Ukraine request the same documents in Russian. Finding professionals who are capable of producing high-quality translations, have a deep knowledge of economics, health finance and management issues, are experienced in working with computers, and have access to a PC is difficult in itself. However, searching for qualified translators and interpreters with skills in Ukrainian and those with skills in Russian and/or people with excellent knowledge of both languages is an even bigger challenge.

Another issue often raised by translators is the lack of Russian and Ukrainian equivalents to the terms and phrases used in ZRP documents. This problem requires translators to come up with words that are acceptable in the target language and also convey the true meaning of the original terminology. Quality control of translations is essential to avoid possible misinterpretations. Unfortunately, time and financial constraints often make it impossible to locate appropriate reviewers and complete thorough technical, grammatical and stylistic reviews of materials.

On the whole, translation and interpretation are formidable jobs that require a high degree of professionalism and writing ability. The Program's goal is for exchange among field offices of regularly updated glossaries, completed materials and lessons learned. 

## Recent Activities under the ZdravReform Program

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In Odessa, preliminary results of an assessment of four medical facilities—currently engaged in self-financing—show strong evidence that these facilities are capable of surviving without government support. Follow-up technical assistance is being provided by ZRP. The technical report on these activities is expected to be available this month.

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Two of ZdravReform's intensive demonstration sites—Odessa, Ukraine, and Shymkent, Kazakhstan—now publish monthly updates of IDS activities. Contact the offices for more information on how to receive "Odessa IDS Update" or "Shymkent Review."

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In October, the first family practice in the Altai region opened in conjunction with the Annual Meeting of the Interregional Association of Public Health of Siberia. Ten physicians have been retrained; a family practice curriculum developed; equipment purchased; and four new sites identified for expansion.

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Also in October, a showcase event was held at the Health Committee headquarters in Barnaul to provide updates on the progress of health reform initiatives. Among the issues discussed were payment system reforms, accreditation and licensing systems for facilities and providers, multilevel specialty care in hospitals, and the family practices initiative.



**Reinverting the Pyramid: Reforming Primary Care  
in NIS Health Systems** (Continued from page 4)

receive a capitated rate that includes funds for outpatient and inpatient care. Outpatient services will be paid according to a fee schedule, and hospitals will be paid on a new case-based payment system. FGPs will have the right to refer patients to any facility. Funds not used will be available to be reinvested or to pay bonuses.

The new system in Issyk-kul, which will reinvert the pyramid, is largely in place. The primary care group practices have been formed, and several lessons have been learned already. First, the groups must have their own identity. To accomplish this, physicians should choose their own partners, not be assigned, at least in the initial stages. Practices must have new spatial identities either by remodeling space in existing polyclinics or finding new offices in the community. Second, patients must be part of the reform process. Rather than be assigned to a practice, patients should choose the practice in which to enroll—otherwise they will believe nothing has changed. Third, clinical skills need to be enhanced by providing basic equipment and clinical refresher courses. Finally, financial incentives have to change so that it is possible to earn higher income by conducting a successful practice. Through introducing these reforms, it is possible to build a successful system of primary care.

The goal of health reform is to maximize health with the limited resources that are available to health care. Given the underfunding of the health system, the critical task is to strengthen primary care. A well-functioning system of primary care can provide most of the cost-effective interventions, and a smaller hospital system can provide needed acute care. In the context of the NIS, the question is how to reinvert the pyramid; to shift from a hospital dominated system to one based on primary care.

Reform requires more than just putting practitioners in offices in neighborhoods. It requires creating new units that function as cohesive primary care providers. It requires equipment and clinical training; and perhaps most importantly, it requires changes in financial incentives.

If all of these reforms can be combined, as *ZdravReform* is attempting to demonstrate in the NIS, a new cost-effective health care system can be created based on primary care. 

**ZDRAVREFORM APPROACHES  
TO RESTRUCTURING THE PRIMARY  
CARE SECTOR**

**Dzhezkazgan Oblast, Kazakstan**

Two private family practices have been established in the oblast, each serving 4,000-4,500 residents (with two internists per practice). These practices are located in offices separate from polyclinics, on the first floor of apartment buildings in residential areas of city.

The principal innovation in Dzhezkazgan is to pay private practitioners through the Mandatory Health Insurance (MHI) Fund. One of the factors limiting the growth of private practice is payment. If the private practice is limited to charging user fees to patients for all of its income, only a limited number of practices will be viable. In Dzhezkazgan, the MHI Fund is paying two private practices retrospectively based on the number of visits. This creates competition between the existing polyclinic system and the private practices. The MHI Fund is considering moving towards a prospective capitated payment system and/or the creation of fundholding primary care practices. The Oblast MHI Fund has facilitated the establishment of these practices by providing one-year, no-interest loans for start-up costs (purchase of equipment, supplies, medications, etc.).

These primary care physicians have established contractual arrangements with a pediatrician and obstetrician/gynecologist, to whom patients are referred as needed. This system of primary care provision places a very strong emphasis on continuity of care by the primary care physician, who maintains follow-up contact with and ultimate responsibility for his/her patient through referrals, hospital admissions, and other care processes, resuming complete follow-up care once it is medically indicated.

**Shymkent and South Kazakstan Oblast**

Initial development of family practices in the oblast began in 1992, at which time they were incorporated within existing polyclinics. Since 1994, independent practices have been growing. Currently, there are 22 operational family practices in the oblast—14 in Shymkent and the remainder in rural areas of the oblast. The offices are generally located in residential areas—



some in buildings purchased specifically for this use, others in apartment buildings, still others within and providing services in conjunction with a polyclinic.

Seventy family practice physicians have been trained, and continued training of additional practitioners is planned. The future focus for family practice in the oblast is on rural areas and the transformation of feldsher stations into family practices.

The practices in Shymkent have formed a municipal family practice association. Also, the Association of Family Practitioners, which will receive assistance from *ZdravReform* through training in nongovernmental organization operations, is being formed.

Possible reimbursement mechanisms for primary care practitioners are currently under discussion, with the establishment of a fundholding system among the options. City and oblast authorities have agreed to introduce partial fundholding in practices in Shymkent. The family practices are in need of computer hardware and software and computer training to facilitate operations and financial management. They also need diagnostic equipment.

Several attempts are underway to ascertain public opinion about the growth of family practices in Shymkent. The first is an independent analysis of a subgroup of residents included in the South Kazakstan Oblast health care demand survey (see story on page 12). The responses of 300 families residing in the family practices' catchment areas are being analyzed to gauge levels of satisfaction with care. A limitation to this effort, however, is that there is no way to separate those who actually make use of these practices from those who continue to use the polyclinic.

Therefore, a second survey, designed to gather baseline information in order to monitor changes in primary care services in the pilot area, has been fielded. This survey will be conducted among 300 patients of family practices, 28 family practitioners, and a number of facilities. Questions are designed to gauge levels of satisfaction with care, explore reasons some individuals bypass family practices and seek care directly from hospitals, and examine family practitioner behavior. The provider survey also includes an inventory of available equipment, questions regarding the qualifications and experience of practitioners, and data on patients seen and referral patterns. Results and analysis are expected in December 1995 or January 1996.

### L'viv Oblast, Ukraine

The goal of the Skole rayon demonstration site in L'viv Oblast is rayonwide reform of a primary care delivery system. Currently, there are five primary care clinics operating

in surrounding communities. The *ZdravReform* Program plans to support, through technical assistance, the development of these primary care practices into family practices. Plans include development of eight more practices, and training physicians in family practice medicine. At the request of the Skole Rayon Hospital Health Administrator, this conversion of the primary clinic network has been rescheduled from November 1995 to February 1996. In that month, the new family medicine director for the primary care clinic network will officially begin work.

Currently, a *ZdravReform* consultant is working in Skole to develop recommendations on how to incorporate financial incentives into the primary care delivery system and how to reorganize the clinical and management structures to adapt to the new oblast global budget allocation method that is to be implemented January 1, 1996.

### Altai Region, Russia

*ZdravReform* awarded a grant of \$25,000 to support the development of primary care practices in the Altai region of Siberia. Dr. Nikolai Gerasimenko, Chairman of the Health Committee of Altai Krai, is a strong advocate of improving the primary care sector. The first family practice unit in the city of Barnaul was opened in early October. Currently, there are four potential additional sites for family practices. Equipment has been purchased for the offices selected by Health Committee to participate in the reforms. A family practice curriculum has also been developed with *ZdravReform* assistance, and 10 physicians received retraining to enable them to assume positions within restructured polyclinics as family physicians.

Dr. Valeri Yelykomov, head internist of the Oblast Health Care Committee and a leader the family practice initiative, as well as the physician who opened the first practice were both participants in a *ZdravReform*-sponsored study tour to the United States on polyclinic restructuring. Yelykomov has expressed hope that a family practice department may be opened at the Altai Medical Institute with the assistance of *ZdravReform*.

*ZdravReform* consultants have assisted the Territorial Health Care Committee in drafting enabling legislation for the establishment of capitated payment systems. The introduction of other features of a reformed primary care delivery system, including restrictions on self-referral to specialists, prospective payment for specialist services, and a system of risk incentives for providers, also is part of the Altai Krai initiative. 



The initial results from an unprecedented household health care demand survey in Kazakhstan reveal that nine out of 10 residents believe their health care system needs to be substantially improved. Perhaps even more importantly, a majority of those surveyed last year in eight rayons of Kazakhstan's largest oblast reported they are willing to pay for such improvements.

A team of Kazakstani medical students—under the joint supervision of oblast health ministry officials and *ZdravReform* technical advisors—conducted a survey of 1,847 families, comprising 6,860 residents of the Shymkent, Dzetysaiskii, Pahtauralskii, Tyulkubasskii, Algabaskii, Kirovskii, Arysski, and Syramskii rayons of South Kazakstan Oblast (SKO). The survey, a 31-page questionnaire with over 100 questions, asked about:

- o Family member health histories,
- o Medical treatment sought in the past 30 days,
- o Hospitalizations in the past year,
- o Satisfaction with existing medical services, and
- o Knowledge of and satisfaction with the recently introduced concept of private health insurance.

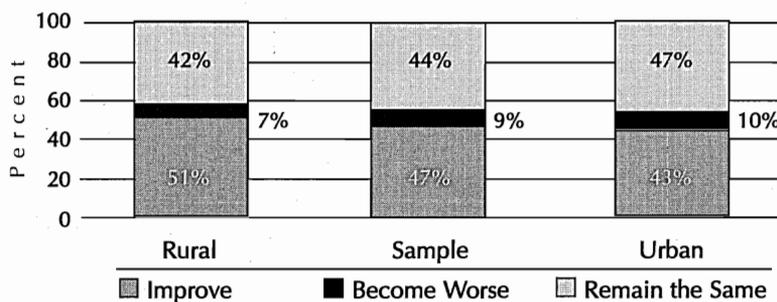
beds or the size of their staff rather than on the number of patients they treated or the types of treatments they provided. In effect, the more beds a hospital or polyclinic had, the more money and equipment it received, regardless of the number of patients treated at each facility, or the success of the treatments.

Today, control of the system in Kazakhstan has shifted to Almaty, but the results are virtually identical. The system, to a large degree, remains highly inefficient, ignores patient preferences, and rewards excessively lengthy hospital stays through its bed-based budget allocation methods. Average length of stay in a Kazakhstan hospital, for example, is about 17 days (21 days in Shymkent according to the survey results), compared to just nine days in the United States.

According to *ZdravReform* Evaluation and Management Information Systems Officer Dr. John Novak, who organized and directed the survey, the survey results indicate that ongoing efforts to reform the health care system in Kazakhstan are on target; that is, they reflect popular opinion. As a result, he says,

## SKO HEALTH DEMAND SURVEY SHOWS CONSUMERS

**Figure 1 Will Voluntary Insurance Improve Health Care?**



The information gleaned from such a health demand survey, which also includes demographic and socioeconomic questions, is routinely used by Western health care planners and policymakers to measure the demand for, and utilization of health services by the population. This approach is unprecedented to those practicing in Kazakhstan, where, until recently, budgets and supplies were controlled from Moscow and allocated to facilities primarily based on their number of

Kazakstani regional health ministry officials and health care professionals advocating and implementing reforms now should have an easier time convincing their colleagues in Almaty that there is public support to institute reforms. "One thing the survey can do is reduce fear among reformers and policymakers about the reactions they'll receive. In fact, it can encourage them because there's more of a groundswell of popular support [for such changes] than they thought."

Still, concedes Novak, a certain amount of resistance to changes—such as an experiment with health care insurance and budget allocations based on the number of patients (successfully) treated rather than size of staff or total number of beds—is likely. "Many bureaucrats have something to lose," he says, "as do many of the [health care] providers unless they increase their productivity and improve the quality of care they provide to their patients."

After a review by South Kazakstani health care



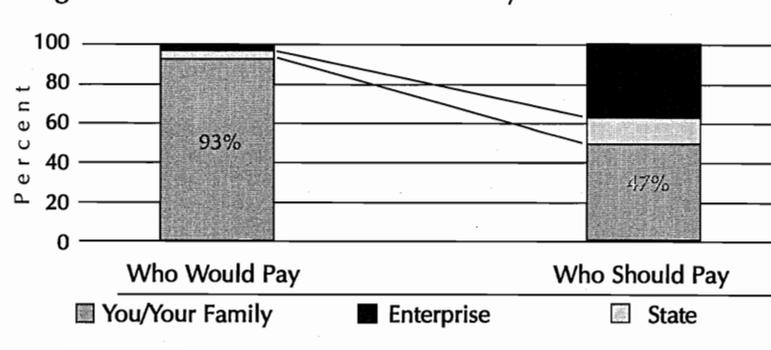
providers and officials, an initial survey report was published in August 1995 (Technical Report No. CAR/KAZ-1 South Kazakstan Oblast Household Survey Report).

In a recent interview, Dr. Novak discussed the survey, why it was done, and what the results reveal about the state of South Kazakstan's current health care system and the changes residents seem willing to support.

"The most important things we tried to learn," he said, "were, number one, what is the demand for health services? We asked some questions about illness or injury, to get a sense of what the morbidity rates were for the population. And then, for those who were ill or injured, we asked if they sought treatment and where they went for services. We wanted to get a measure of present utilization patterns."

Comparing the initial results to a "before snapshot" of the health care system in the eight rayons studied, the data will be used "to assist in planning implementation of current reforms." They also will

**Figure 2 Who Would and Should Pay for Medical Care?**



their rayon (see figure 1).

Closely tied to questions about insurance was a series of questions about respondents' willingness to pay out of their own pockets for improved health care services. In a country in which health care has been the sole responsibility of the state for nearly 80 years, 93 percent of respondents anticipated that if they became ill, they (or their families) would have to pay for health care costs. Slightly more than half that number (47 percent)

## VILL PAY FOR IMPROVEMENTS IN HEALTH CARE

provide "a baseline against which to evaluate the results of these reforms" when *ZdravReform* does an "after snapshot" (a follow-up survey) in South Kazakstan.

Novak said some of the most interesting findings dealt with respondents' awareness of and willingness to pay for health care insurance. "We were interested in people's knowledge of insurance, their attitudes toward insurance," he said. "Previously, there had been some private insurance offered in the oblast. We asked about participation. Very few people had participated."

Indeed, the survey revealed that more than half the respondents had never even heard about "voluntary insurance" that had been offered in several South Kazakstan rayons on an experimental basis. Fewer still—just 63 of 4,373 respondents who answered this question—had been enrolled in such a plan in the past year. Nevertheless, respondents overall were surprisingly optimistic about what insurance could potentially do for them: 51 percent of rural respondents and 43 percent of urban respondents said they believed that voluntary insurance would improve health care in

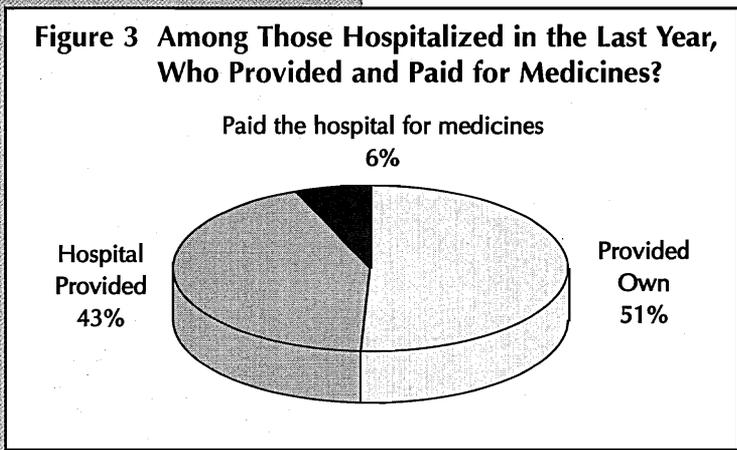
expressed the opinion that individuals and families should be responsible for contributing (see figure 2), and 62 percent agreed that they should help pay the costs of services if they became ill.

On the other hand, 53 percent of respondents replying to the question of who should be responsible for paying for health care said the government or employers should pay the bill. Still, these figures indicate good news for health officials in Kazakstan, who are scrambling for ways to generate nonstate revenues to cover health care costs in a time of extreme fiscal austerity. Last year, Kazakstan set aside just 2.8 percent of GNP to health care—less than half of what it allocated a decade earlier. But, this is bad news for less affluent Kazakstanis, who in their responses indicated substantially less willingness to bear the costs of their own medical care.

A system of private health insurance would mark a dramatic departure from the current health care system under which medical treatment and drugs are ostensibly provided free of charge to all citizens by the government. In fact, there is a considerable amount of



**Figure 3 Among Those Hospitalized in the Last Year, Who Provided and Paid for Medicines?**



out-of-pocket payment being made to health providers such as physicians and surgeons, as well as for the purchase of pharmaceuticals.

“One of the things we learned in this survey,” says John Novak, “is that, even though medicines are supposed to be free and available, they’re not. There’s a shortage and, in many cases, where they’re available, even in public institutions, patients have to pay for them.”

Indeed, one set of questions put to respondents concerned drugs they received in hospital stays during the past year (see figure 3). As inpatients, more than half the respondents (51 percent) provided their own medicines; an additional 6 percent paid the hospital for their medicines; while 43 percent received their medicines from the hospital at no charge. Average personal spending on medicines per hospitalization was 901 tenge, or around US\$18 (at the exchange rate during the survey).

In a question regarding the use of medicines outside the hospital, answers appeared to break down along economic lines. Nearly twice as many higher-income respondents (23 percent) as lower-income respondents (14 percent) had used medicines in the past seven days. This discrepancy may also reflect a generally higher level of self-perceived healthiness in lower-income respondents. Sixty-four percent of the poorer people thought they were in good health, compared to 54 percent of the richer respondents. There were similar discrepancies in how rural and urban respondents rated their own state of health. Sixty-seven percent of the rural respondents thought they were in

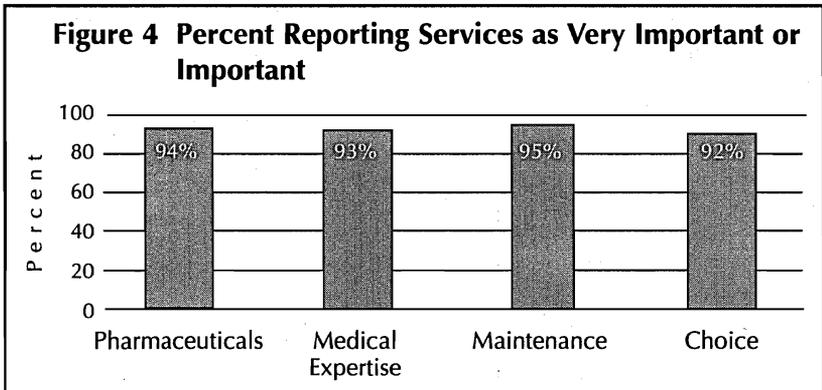
“very good” or “good” health compared to 52 percent of the urban respondents.

Perhaps the most important data to emerge from the survey relate to a more basic question: Indicate which of the following services you find most important and which least important:

- A. A greater selection and availability of pharmaceuticals.
- B. A higher standard of medical expertise among service providers.
- C. Improved maintenance of health facilities and medical equipment.
- D. Improved physician/hospital choice.

Respondents were asked to rank the statements on a four-point scale (from “01—not important,” to “04—very important”). An overwhelming majority felt improvement was crucial in all four of these aspects of the health care system (see figure 4). Says Novak: “I expected some sort of differentiation, but the result was that over 90 percent of the respondents said that all four of these were either ‘important’ or ‘very important.’ So, without question, people are saying they want improved services.”

**Figure 4 Percent Reporting Services as Very Important or Important**



Whether or not such improvements are actually made will depend on a variety of factors, especially economic stability. Nevertheless, the “before snapshot” provided by the health care survey will give reformers a rolling start. “The data from the survey can be used by health care providers to improve their efficiency, improve their services, and make them more attractive to customers,” says Novak. This market-driven approach to health care management is “unprecedented” in the NIS. 🌟

# ZdravReform Conducts Study Tour in Washington D.C. Area on Health Insurance and Related Issues

Two Kazaks, one Moldovan, and 24 Russians spent two weeks in the Washington D.C. area for a comprehensive study tour that provided an overview of management and payment of independent practitioners, as well as operation of modern health insurance companies and integrated health plans. This ninth study tour conducted under the ZdravReform Program took place October 13-27. Among the highlights of the tour were a technical summary of a trip to Kaiser Permanente and a dinner in an American home.

The tour began with an introduction to the U.S. health care system, payment systems, and managed care in presentations by Abt Associates health care consultants. These presentations provided a useful orientation for the site visits that followed.

The 27 participants divided into two smaller groups for most site visits. Group A, comprised of directors of health insurance companies that belong to the Moscow Health Insurance Association, focused on information and tools important to the development, management, and payment of independent practitioners. Through visits to the American Medical Association, family and physician practices, and several hospitals in Maryland and Virginia, the participants gained a broad perspective of issues facing establishment and management of a general practitioners office. Linda Moll, ZdravReform's Bethesda-based training coordinator, explains "one of the valuable aspects of the tour was demonstrating the relationships between doctors and hospitals or doctors and insurance companies, and the division of medical and administrative responsibilities.

Group A viewed as valuable the presentation of characteristics of family practices by Medical organizations, such as Management Solutions in Martinsburg, West Virginia. Participants hope to use the data presented as a guide in their own physician practice development.

Group B, comprised of directors from mandatory health insurance funds, focused on the operations of modern health insurance companies and integrated health plans,

such as health maintenance organizations. Group B visited Blue Cross and Blue Shield, Kaiser Permanente, Mid-Atlantic Medical Services Inc., and several hospitals and associations. This combination of visits showed the group different models of health insurance in the United States. According to Tatiana Makarova (ZdravReform technical expert based in Moscow and leader of the group), several Russian participants explained that the visit to the Maryland Hospital Association "made the whole tour come together." The association presented data from the Maryland Quality Indicators Program, which tracks leading indicators for U.S. and international facilities, including one hospital in Moscow.

The tour ended with several wrap-up sessions to discuss ways in which the information presented during the study tour could be applied to local Kazakstani, Moldovan, and Russian environments. Possibilities ranged from very broad applications, such as creating a health care provider association or increasing medical and financial efficiency to more defined approaches, such as improved physician follow-up to patient needs and automated accounting centers.

One Russian participant expressed his appreciation for the "openness, high degree of professionalism, and willingness to share experiences from American colleagues." Makarova continues to receive positive feedback from participants. 

**On the last day of the study tour, participants (shown below) met at Abt Associates to present their impressions of what they had learned.**



# ZdravReform ASSISTS PHARMACEUTICAL SECTOR PRIVATIZATION IN KAZAKSTAN

With assistance from the ZdravReform Program, Kazakhstan is engaged in full-scale privatization of its pharmaceutical sector. Beginning in January 1995, with help from ZdravReform advisors, health professionals and officials in Kazakhstan began work toward "staged privatization" of the State Holding Company (SHC) Farmatsiya's assets. The effort began with legislative reforms to facilitate the privatization process and has proceeded to the current stage of auctioning retail pharmacies.

As of November 15, 1995, 172 pharmacies have been auctioned and 79 sold. This process has so far generated revenues of 60 million tenge or US\$1 million. Oblast restructuring plans have been in process since June 1995, and a master plan for privatization is currently under review by the State Property Committee (GKI). This plan provides for privatization of over 70 percent (or 900) of Farmatsiya's 1365 retail outlets.

**Backdrop for the ZdravReform Initiative in Kazakhstan.** Kazakhstan has roughly one pharmacist for every 1,400 people. Equivalent figures in are: Australia 1,678, Canada 1,399, Germany 2,092, U.K. 3,242, U.S. 1,581. However, this relative abundance of pharmacies in Kazakhstan does not mean that there is abundance or even adequate availability of pharmaceuticals.

Before privatization began, a generous drug benefits package, which covered 80 percent of the population, was guaranteed by law. However, budget allocations did not cover anticipated drug demand. In many cases, patients had to purchase drugs. Hospital inpatients often received a list of drugs and supplies and were told to go out and buy them. Once they procured everything on the list, the hospital would schedule their procedure.

In August 1993, a Presidential Decree transformed the status of SHC Farmatsiya from a wholly state-owned and -operated entity under the direct control of the Ministry of Health to an independent, commercialized joint-stock ("holding") company to an independent and self-financed entity.

However, Farmatsiya, like many other holdings, was given conflicting mandates. On the one hand, it was required to take over the governmental function of purchasing and distributing drugs, often for free, to large segments of the population. On the other hand, it was cut off from budget allocations and forced to become self-financing. The way to fulfill both of these functions was either to reduce the quantities of medicines it provided to protected population groups, or to increase prices for drugs it sold to nonprotected groups. Farmatsiya did both, resulting in shortages of many drugs and exceptionally high prices for commercially available drugs.

The combination of Farmatsiya's conflicting mandate and the worsening economic situation led to the continued drug shortages, price inflation, and a

ballooning financing gap between the benefits package promised by the state and the funds available to pay for that package. The gap between drug benefits and total demand indicated that the Farmatsiya system was unable to provide all the drug benefits mandated by law, so people began to pay commercial prices for drugs they were entitled to get free of charge.

Meanwhile the entire Farmatsiya system amassed debts of some 300 million tenge (US\$5 million), owed to the Ministry of Health, based on its inability to repay government credits supplied for purchases of drugs. Additional debt included about US\$3.5 million owed to the Russian Federation for imports of drugs and nery US\$14 million in retail sector debt for consignment supplies of drugs that were never reimbursed.

**ZdravReform's Effort to Privatize Farmatsiya.** The seeds of the current privatization effort were sown in November 1994 when, at the request of USAID and the Ministry of Health of the Republic of Kazakhstan, ZdravReform sent a team of experts to Kazakhstan to examine the existing structure and operations of the pharmaceutical distribution system and the SHC Farmatsiya, as well as to develop recommendations and a program of technical assistance to restructure the system to operate more equitably and efficiently. The team also recommended a series of measures to encourage rapid growth of the private pharmacy sector, as an essential means of easing the problems with pharmaceutical supply and pricing.

The ZdravReform team proposed a multifaceted approach to pharmaceutical sector reform including:

- Privatizing retail pharmacies and wholesale distribution,
- Developing a computerized national drug information system and drug formulary,
- Revising the drug benefits package provided by the State,
- Rendering the pharmacy licensing and drug registrations procedures more open and transparent, and
- Developing a mechanism whereby drug benefits still provided by the State after privatization could be furnished to the population through private pharmacies, via some form of reimbursement procedure.

The goals of privatization program are to reduce monopoly power and increase competition, remove the state from commercial activities, eliminate dual commercial/regulatory role of state, pay for drug benefits out of the budget, thus making policy and benefit choices more explicit. Privatizing a significant portion of retail pharmacies would reduce Farmatsiya's ability to set prices in the commercial sector, in which it has done in order to subsidize its loss-making function of providing drug benefits. Forcing the State to provide drug benefits from



budgetary allocations may force government to reconsider and ultimately reduce benefits to a more affordable level.

ZdravReform experts worked closely with the Ministry of Health to develop objective criteria for selecting Farmatsiya assets to be privatized. These criteria spelled out which assets would be assumed by the Ministry of Health, to be operated on a noncommercial basis, thus ensuring continued provision of essential drugs to populations not traditionally well-served.

In April 1995, a Cabinet decree officially dissolved Farmatsiya, and in June 1995, the State Property Committee mandated that oblasts implement this decree by submitting restructuring plans. Asset selection criteria were established, and oblast officials in Dzhezkazgan, Almaty City, and Pavlodar, as well as Dzhambul and other oblasts, followed the GKI directive by submitting detailed plans for retail pharmacy privatization.

A number of obstacles slowed the privatization process somewhat during the summer of 1995, most notably:

- Unresolved issues related to allocating debts owed by the SHC Farmatsiya (primarily to the Ministry of Finance) and proceeds of asset sales and
- Bureaucratic complications resulting from the split of GKI's authority into two divisions—one responsible for management of state property and the other for privatization.

Reformers also faced an uphill struggle in convincing Kazakstan's nearly 17 million residents that the reforms are in their best interest. As Charles Krakoff, ZdravReform's resident advisor on pharmacy privatization in Kazakstan, states, "People feel that the implicit social contract of Soviet times, 'do as you are told and you will be provided most of the time with most of what you need to live—is still, or still ought to be, in force. There is a fear that state benefits may disappear entirely if reform proceeds. This doesn't doom reform efforts, but it certainly presents more of a challenge.

*Consequences of Privatization.* Though there has been no systematic survey of drug availability and prices in Kazakstan since privatization, recent anecdotal information suggests that prices are lower; service is better and more drugs are available. Comparison of state versus private pharmacies in Shymkent shows that state stores carried only 38 percent of tracer drugs, while private pharmacies have available over 70 percent. Similar comparison in Pavlodar reveals 33-percent tracer drug availability level at state pharmacies versus 66 percent at private pharmacies.

Having successfully initiated the segmentation of Farmatsiya State Holding Company and the oblast Farmatsiya joint-stock companies in Kazakstan and having begun an ambitious program of privatization of retail pharmacies, ZdravReform is eager to apply the experience from Kazakstan to other countries on the region. Below is a brief description of the status of

pharmaceutical reforms in Kyrgyzstan and Uzbekistan. As yet, no ZdravReform activities have been planned in these countries.

Starting in September 1994, the government of Kyrgyzstan began to segment and privatize Farmatsiya. This was consistent with its overall approach to privatization. The government performed all small-scale privatization with no assistance from international donors. The results have been mixed. The drug distribution system remains highly concentrated, both at wholesale and retail levels; however, retail pharmacies, joint-stock companies, oblast health departments, and health facilities are free to buy drugs from any source. The government has limited retail markups on drugs to 20 percent. This policy, which is designed to control prices, may instead prevent the development of a truly competitive system and keep prices artificially high.

Nonetheless, Kyrgyzstan has succeeded in establishing a reasonably transparent and fair system of drug distribution in which private sector interests play an important role. This will eventually lead to price reductions and a greater responsiveness on the part of pharmaceutical wholesalers and retailers to the needs of the market. Despite the introduction of price controls, other government regulation in controlling the distribution of drugs has been reduced.

Of the 450 retail pharmacies, the government transferred 80 mainly hospital and interhospital pharmacies to oblast health departments to be managed as part of the hospitals. Forty-five (or 10 percent) of the retail pharmacies were privatized through open small-scale auctions, and approximately 80 retail pharmacies were retained by the joint-stock companies established as successors to Farmatsiya. The government has transferred free of charge ownership of nearly 230 retail pharmacies to their employees.

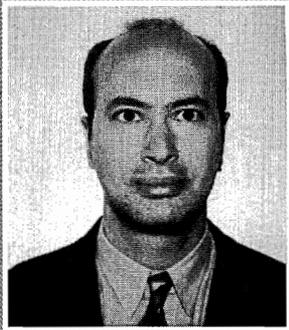
In Uzbekistan, efforts to privatize that republic's pharmaceutical sector have proceeded rapidly. The government transformed the state-run Farmatsiya into an independent, joint-stock association known as Dori-Darmon more than two years ago. Then in March 1994, the Government instructed Dori-Darmon to privatize approximately 2,200 of the country's 2,570 pharmacies—hospital and interhospital pharmacies, warehouses and a few other facilities were excluded—and by the end of 1994, this task had largely been completed. Additional steps such as the lifting of price controls, and the provision of tax relief and low-interest loans to pharmacies, also were taken.

To date, drug availability reportedly has increased from around 25-to-30 percent of patients' needs to around 45 percent, and net debt within the system is low, less than 1 percent of sales. Over the long run, however, Uzbekistan may face obstacles because it still retains considerable control over the pharmacy sector, including the ability to discriminate among operators and to obstruct private sector growth in general. 



# Profiles of the ZdravReform Program's Key Staff

## Regional Director for Ukraine, Moldova and Belarus



Marc Stone, Regional Director for Ukraine, Moldova, and Belarus, is a natural to work for the ZdravReform Program in Ukraine. One side of his family came from Ukraine: 90 years ago his great-grandmother lived a few blocks from his current Kiev apartment.

Stone first traveled to Ukraine 20 years ago when he was in his first year of medical school. He took a month-long trip to what was then the Soviet Union, to visit health facilities and meet Soviet medical students. He visited Chisinau, L'viv, Leningrad, Moscow, Odessa, and Vilnius, and he remembers that trip as one of the most exciting experiences of his life.

Dr. Stone's professional experience as both as a physician and a health care policymaker also make him well-suited for his current position. During his career, Stone has gained experience in virtually every type of clinical setting: a small rural hospital, an urban hospital, a Veterans Administration hospital, public and private facilities, a group practice, a health maintenance organization, an emergency room, and a nursing home. Stone has a bachelor's degree in economics from Yale University, an M.D. from the University of Illinois, and is certified in internal medicine. He was chief resident in internal medicine

at Cook County Hospital in Chicago in the early 1980s, after which he had fellowships at the University of Iowa and Indiana University. Following the fellowships, he joined the staff of the National Naval Medical Center.

From 1990 to 1992, Stone worked as medical officer in the Center for Medical Effectiveness Research at the Agency for Health Care Policy and Research at the Department of Health and Human Services. He was cofounder of their program in outcomes and medical effectiveness research. Stone then worked for three years as medical advisor in the Office of Payment Policy, Bureau of Policy Development at the Health Care Financing Administration (HCFA). He was HCFA's resident expert on the resource-based relative value scale, which is used to create the physician fee schedule, in widespread use in the United States today. He also served as their medical advisor for technology assessment.

When Stone is not working, he likes to explore Kiev and travel around the region, study Russian, read, listen to 20th century classical music, and watch old movies, especially the Marx brothers. He lives in Kiev with his cat Imi. 🐾

## ZdravReform/Russia Holds Mini-conference in St. Petersburg

In St. Petersburg on October 17 and 18, ZdravReform Russia conducted a series of presentations aimed at further stimulating reform initiatives in quality improvement. Nearly 500 health sector leaders and policymakers attended the presentations, which were held in conjunction with the Annual Meeting of the U.S. Agency for International Development-sponsored Partnership Program. Below is a list of the Zdrav presentations:

### *"Quality Assurance in New Payment Methods"*

Panelists: Pamela Garside, London, England; Ludmilla Isakova, Department of Health Economics, Health Ministry Reser Lab, Kemerovo, Russia; James Rice, Russia ZdravReform Program.

### *"Measuring and Reporting Quality to the Public and to Purchasers of Health Care"*

Panelists: Sheila Leatherman, Center for Health Policy and Evaluation, United Health Care Corporation, Minneapolis, Minnesota; Galina Zarik, Kemerovo, Russia; Stanley Tillinghast, Russia ZdravReform Program

### *"Accreditation of Health Care"*

Panelists: K. Tina Donahue, Joint Commission International; representatives of the Health Care Committee in Novosibirsk and Barnaul, Russia.

### *"Information System Needs for Quality Assurance"*

Panelists: Kevin Woodard, Russia ZdravReform Program; and Roman Zelkovich, Center for Information and Data Processing, Kuzbass Regional Administration Health Department, Kemerovo, Russia. 🐾

# List of Newly Available Publications (as of 11/1/95)

## TRIP REPORTS

- NIS-2 Report from Marty Makinen on Trip to Central Asia and Ukraine.

### Russian Federation

- RUS-8 Design and Implementation of an Integrated System of Cost Accounting and Analysis: The Case of the Tomsk Oblast Teaching Hospital in Siberia, Russia, by Dec. 3-23, 1994, by Alexander Telyukov.
- RUS-9 Country Action Plan Preparation for the ZdravReform Project in the Russian Federation, Jan. 25-Feb. 24, 1995, by Ernest E. Petrich, EP&A.
- RUS-10 Tomsk Seminar on the Development of Methods for Strategic Financial Planning, Tomsk City, Russia, Dec. 4-21, 1994, by Daniel Sherman and Edward King.
- RUS-11 Information Systems Related to Health Care Finance and Clinical Systems, Novosibirsk, Russia, Feb. 15-March 8, 1995, by Loren Shellenbarger.
- RUS-12 Technical Assistance to the Novoaltai City Hospital to Create Multiple Levels of Inpatient Care, Altai Krai, Russia, Feb. 15-March 1, 1995, by Peter Wilson.
- RUS-13 Technical Assistance for ZdravReform Grant One, Barnaul, Russia, Feb. 16-March 2, 1995 by James R. Owens, Jr., HHS, HCFA.
- RUS-14 Developing and Testing Methods of Payment for Ambulatory Health Services, Kemerovo, Russia, by Josh Coburn.
- RUS-15 Development of Family Practice ASOPO-Life Joint Stock Insurance Company in Novosibirsk, Feb. 10-March 4, 1995, by Jacqueline Carter-Matsapola.
- RUS-16 Technical Assessment in 2 Oblasts--Kaluga and Tver with the World Bank Team, April 13-May 2, 1995, by Jack Langenbrunner.
- RUS-17 Russian Polyclinic Study Tour of Primary Care and Group Practice in the United States, Jan. 21-Feb. 4, 1995, by David Miller.
- RUS-18 ZdravReform Grant One: Barnaul Development of a Conceptual Framework of Family Practice, Altai Krai, Russia, by Dewees F. Brown.
- RUS-19 Trip Report to Tula, Russia, May 8-18, 1995, by Robert Chodos, Warren Paley and Nancy Stewart, Albany Medical College.
- RUS-20 Training of Russian Physicians in Total Quality Management, Santa Cruz, California, March 18-April 8, 1995, by Hans F. Loken, EP&A.
- RUS-21 Developing a Total Quality Management System in Health Care, Novosibirsk, Russia, April 21-30, 1995, by Richard J. Coffey, EP&A.
- RUS-22 Training of Russian Physicians in Total Quality Management, Novosibirsk, Russia, April 24-28, 1995, Hans F. Loken, E. Petrich and Associates.
- RUS-23 St. Petersburg Forum on Public Health, St. Petersburg, Russia, June 22-25, 1995, Eugene Feingold, University of Michigan School of Public Health.

## TECHNICAL NOTES (TN) AND TECHNICAL REPORTS (TR)

- TR UKR-4 Improving Efficiency, Quality and Access under Global Budgeting at City Hospital Number One, L'viv, Ukraine, by Annemarie Wouters and Peter Wilson, August 1995.
- TR UKR-5 An Assessment of Plans to Implement per Capita Financing in the Health System of L'viv Oblast, by James Knowles and Robin Barlow, September 1995
- TN CAR-1 Present State and Future Needs of Primary Care in Kazakhstan and Kyrgyzstan, by Julian Tudor Hart and Mary Hart, August 1995.

- RUS-24 Technical Assessment and Development of a Technical Assistance and Training Strategy in Two Oblasts Kaluga and Tver with the World Bank Team, June 15-28, 1995, by Jack Langenbrunner.

### Central Asia

- CAR-2 Present State and Future Needs of Primary Care in Kazakhstan and Kyrgyzstan, March 18-April 7, 1995, by Julian Tudor Hart and Mary Hart.
- CAR-3 Logistics Planning for the Turkey Study Tour on the Manufacture, Distribution and Sale of Pharmaceuticals, by James Glucksman.
- CAR/KAZ-9 In-Country Training: Insurance and Health Management, Feb. 1-28, 1995, by Leta Finch, VII.
- CAR/KAZ-10 Refinement of the South Kazakhstan Workplan and Presentation at the Universal Health Conference, April 21-May 4, 1995, by Marty Makinen.
- CAR/KAZ-11 Household Health Utilization Survey in Shymkent, Kazakhstan, Sept. 4-Oct. 27, 1994, by John Novak and Victoria Goldin.
- CAR/KAZ-12 Establishing a Drug Information System in Kazakhstan, Feb. 16-June 7, 1995, by John Kaufman.
- CAR/KAZ-13 Developing and Extending a Technical Assistance and Training Strategy for South Kazakhstan Oblast Intensive Demonstration Site, July 16-24, 1995, by Jack Langenbrunner.
- CAR/KAZ-14 Provider Payment Reforms in Central Asia, July 24-Aug. 4, 1995, by Alexander Telyukov.
- CAR/KAZ-15 Development of an Integrated Delivery System in Pilot Facilities in South Kazakhstan Oblast, Aug. 1-8, 1995, by Roger Birnbaum.
- CAR/KAZ-16 Trip Report and Workplan Options for Dzhezkazgan Oblast, Aug. 23-Sept. 3, 1995, by Gary Gaumer.
- CAR/KAZ-17 Quality Assurance Workshop, Shymkent, Kazakhstan, Sept. 11-30, 1995, by Lauren Jones.
- CAR/KYR-3 Cost Centers and Step-down Cost Allocation, Jan. 19-Feb. 11, 1995, by John R. Gass, IESC.
- CAR/KYR-4 Technical Assessment and Strategy for "Roll-out" of Issyk-kul Oblast Intensive Demonstration Site Program (with World Bank team), Feb. 16-March 16, 1995, Issyk-Kul Oblast, Kyrgyzstan, by Jack Langenbrunner.
- CAR/KYR-5 Needs Assessment of Primary Care Physicians in Karakol, Issyk-kul Oblast Kyrgyzstan, April 4-14, 1995, by Bob Buxbaum.
- CAR/KYR-6 Health Facility Planning in the Issyk-kul Oblast Intensive Demonstration Site, Karakol, Kyrgyzstan, April 1-16, 1995, by Susan Monserud, EP&A.
- CAR/KYR-7 Evaluation of Legal Questions Related to Issyk-kul Oblast Demonstration Site, May 21-June 6, 1995, Karakol, Kyrgyzstan, by Thomas Van Cooper
- CAR/KYR-8 Health Systems Development and Financial Management of the APTKs in the Issyk-kul Oblast Demonstration Area, June 17-July 11, 1995, Karakol, Kyrgyzstan, by George Purvis, III.
- CAR/KYR-9 Technical Assistance/Evaluation of ZdravReform Program in Issyk-kul Oblast and Strategic Development of Reform "Roll-out" under Proposed World Bank Loan Program (with World Bank team), June 28-July 15, 1995, Issyk-Kul Oblast, Kyrgyzstan, by Jack Langenbrunner.
- CAR/KYR-10 Financial Management of the FGP's and Organizational Development of MHIF/OHD in the Issyk-kul Oblast Demonstration Area, Kyrgyzstan, Sept. 17-Oct. 14, 1995, by George Purvis, III.
- CAR/KYR-11 Revolving Drug Fund Development and Fact-Finding Mission to Bishkek, Kyrgyzstan, Oct. 9-13, 1995, by George Purvis, III.
- CAR/KYR-12 Pharmacy Privatization in Kyrgyzstan, Oct. 9-13, 1995, by Charles Krakoff.
- CAR/KYR-13 Design of a Case-based Hospital Payment System in Karakol, Kyrgyzstan, Sept. 8-23, 1995, by Grace Carter.

## SPECIAL REPORTS

- NIS-4 Health Financing Reforms in the New Independent States: Options and Experience, WHO Conference Presentation, February 1995, by Jack Langenbrunner.
- NIS-5 Evidence from a Provider Payment System Demonstration in the former Soviet Union: Lessons for Primary Care? Association for Health Services Research Conference Presentation, June 1995, by Jack Langenbrunner and Igor Sheiman.
- NIS-6 Case Grouping and Rate Setting from a Perspective of Incentive-based Reimbursement for Inpatient Care: A Guide to Methodology, by Alexander Telyukov, June 1995.
- CAR/KAZ-2 Morbidity Indicators Available through Government Sources in Kazakhstan, March 26, 1995, by Mimi Church and Eugene Koutanov.
- CAR/KAZ-3 Research Report: The Flow of Funds Analysis from a Perspective of Mandatory Health Insurance: The Case of Issyk-kul Oblast, Kyrgyzstan, by Alexander Telyukov, May 1995.
- CAR/TUR-1 Preliminary Analysis of Aggregate-level and Facility-level Financial and Utilization Data in Turkmenistan by Sheila O'Dougherty, Eugene Koutanov and Alexander Danilenko, April 1995.

### Moldova

- MOL-1 Study Tour to the United States and Canada by Senior Health Officials from the Republic of Moldova, June 16-30, by Peter Hauslohner.
- MOL-2 Assistance to Experimental Rayons to Develop Managed Care in the Republic of Moldova, Aug. 13-19, 1995, by Warren Paley, and Nancy Stewart

### Ukraine

- UKR-10 Odessa Ukraine IDS Planning Visit, Feb. 18-March 4, 1995, by Marty Makinen, Linda Moll, DA, and Tom Wittenberg.
- UKR-11 Study Tour by Senior Health Officials from Ukraine: Health Care and Health Policy in the United States, Jan. 21-Feb. 4, 1995, by Peter Hauslohner and Kevin Quinn. (binder of materials also available)
- UKR-12 Report of the L'viv Intensive Demonstration Site Planning Team, Feb. 20-March 12, 1995, by Donald Harbick, EP&A, Annemarie Wouters, and Boris Uspensky.
- UKR-13 Licensing and Accreditation System for Health Facilities in Ukraine, June 9-24, 1995, by Jean Yan, QHR and Greg Becker.
- UKR-14 Evaluation of the Medical Economics Automation (MEDECA) System in Dnipropetrovsk, Ukraine, July 10-21, 1995, by Josh Coburn.
- UKR-15 L'viv Intensive Demonstration Site, Feb. 20-March 12, 1995, by Donald Harbick, EP&A.
- UKR-16 Trip to L'viv, April 17-May 12, 1995, by Donald Harbick, EP&A.
- UKR-17 Certification, Licensing and Orientation of Moldovan Study Tour Participants, L'viv, Ukraine, June 12-27, 1995, by Donald Harbick, EP&A.
- UKR-18 Trip to L'viv, Ukraine, July 19-Aug. 8, 1995, by John Stevens.
- UKR-19 Trip to Ukraine, July 10-22, 1995, by Nancy Plelemeier.
- UKR-20 L'viv Intensive Demonstration Site: Acting Site Coordinator Report, July 8-Aug. 6, 1995, by Annemarie Wouters.

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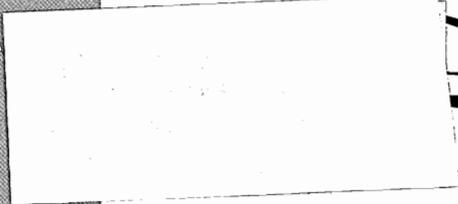
# Vital

A publication of the  
ZdravReform Program

Issue 3, Spring 1996

Checking the pulse of health reform in the NIS

what's inside



# Signs

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## NIS HEALTH CARE REFORM: *Facts, Trends, Interim Conclusions*

By Alexander Telyukov, PhD, Senior Health Economist, ZdravReform Program

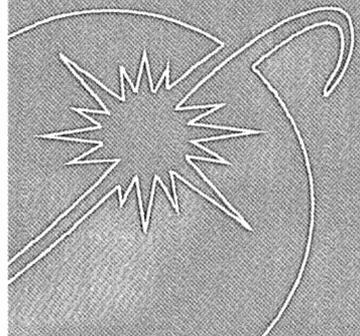
The former USSR's health care system was both praised and criticized. The global community praised the health system for its emphasis on universal access to comprehensive care and commitment to socially just principles. But domestic policy analysts, consumers, and providers criticized it for inefficient command-and-control planning, inability to back up ambitious objectives with adequate resources, and rationing of care based on social favoritism. Health care reforms emerged in the late 1980s as an overdue response to the widening gap between ideological principles and health sector performance, the latter constrained by scarce resources and lack of incentives.

Innovators first articulated clear goals for national health reform in 1990-91 when they proposed a new pattern of health financing and administration for Russia. This pattern included new approaches to financing and management to increase the supply of services, foster equity, and enhance efficiency. To achieve these goals, an insurance-based mechanism of allocating funds would supplement insufficient health care financing; decentralized management would make decision making more responsive to local needs and strengthen mechanisms to ensure compliance with reforms; and competitive contracting and

performance-based reimbursement would create incentives for providers to increase the supply of services while encouraging cost-consciousness.

**Mechanisms for Reform.** The Health Insurance Act, which was passed during the summer of 1991, then amended in 1993, is the legal foundation for health sector reform in Russia. The Act makes Russia's entire population eligible for comprehensive statutory health coverage financed from two sources: an earmarked payroll tax levied on employers to cover their employees and on-budget premiums to cover government employees and nonworking populations. Contributions from both sources are pooled into the newly created territorial Mandatory Health Insurance (MHI) Funds, which pay accredited health care facilities through contracts to provide required health care benefits to patients. Because each territory may broaden the MHI benefits package to include "locally relevant" care, basic coverage is almost all-inclusive.

Either the local subsidiaries of the MHI Fund or nonprofit insurance companies underwrite employers for the MHI, reimbursing and monitoring providers of care. An MHI Fund pays insurance companies an age/sex-adjusted capitation rate per subscriber. Since community rating



restricts risk selection, competition among insurance companies is focused on market share, with competitive advantage coming from the consumer-friendliness of a carrier in dealing with employers, its ability to enforce tax compliance, its exercise of self-restraint as regards administrative overheads, and its ability to gain Fund approval by effective control of quality of care.

Russian health insurance—defined by the presence of comprehensive coverage, a single territory-wide payer, the major role of public monies, and the absence of experience rating—resembles in many ways the Canadian system. In Russia, the introduction of MHI indicated a revolutionary step towards separation of health financing from the delivery of services.

Health service delivery, although a target of innovative experiments in the 1980s, remained largely outside of the reform agenda in the 1990s. Providers of care received no legal endorsement for autonomy. Performance-based methods of reimbursement, although proclaimed a preferred approach, were not operationalized. A shift toward outpatient care in general and primary care in particular was neither set forth as a structural policy nor as an incentive-driven goal. Consumers did not push providers to deliver care in a cost-conscious manner.

***Progress in Implementing Reform.*** After a year of organizational disarray, health insurance reform took off in 1994 and has been gaining momentum ever since. Data as of January 1995, reported by the Federal MHI Fund, reveal a number of trends, accomplishments, and problems.

- The MHI administrative network has been established. Territorial MHI Funds now operate in 86 of 89 territories of the Russian Federation. There are 1,103

subsidiaries serving local communities as MHI transaction centers; 571 of them also perform underwriting functions. There are 10,500 MHI staff.

- MHI coverage is spreading, yet it remains far from comprehensive. Coverage quadrupled between mid-1993 and early 1995: 71.9 million persons, or 48.2 percent of Russia's population received MHI policies.
- The government, which together with employers is one of the two driving forces in MHI coverage, remains reluctant to give budgetary resources to MHI Funds. Although government contributions should cover 56 percent of the population, they currently pay for only 24 percent of MHI enrollees. In 1994, though numbers were up dramatically from 1993, only 51 territories pooled funds from governments and employers.
- The compliance rate among employers has reached 90.9 percent, evidence of the MHI system's tax collection service being operational in most locations.
- Local subsidiaries of the MHI Funds coexist with private insurance companies in only 16 territories, having been viewed from the outset as rivals, not partners. In these 16, Fund subsidiaries and independent insurance carriers have comparable shares in the MHI operation. In 30 territories, insurance companies enjoy a much larger share of MHI business, while in 40 territories subsidiaries prevail. The national pattern in the division of labor between the two systems of institutions is as follows: Independent insurers focus on underwriting employers by signing MHI contracts with them. So far they have issued 3.5 times more MHI policies than the subsidiaries. Subsidiaries specialize in reimbursing providers.

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# ZdravReform Holds Regional Technical Conference to Share Lessons Learned

by Marty Makinen, PhD, Technical Deputy ZdravReform Program

The ZdravReform Regional Technical Conference, held December 14-15, 1995 in Almaty, Kazakstan, disseminated information about Program progress and lessons learned and provided an opportunity for cross-fertilization of ideas among professionals who are engaged in health reform and are from the countries of the New Independent States (NIS). More than 50 papers on various aspects of financing, management, and organization reforms were presented to an audience of 213, including more than 160 practitioners of reform from Kazakstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan, and personnel from international assistance organizations.

The papers presented at the Conference covered a broad array of reform initiatives in various stages of execution. This permitted Conference participants to maximize learning about what has worked, what obstacles have been encountered and whether and how they have been overcome, and what ideas have been proposed but are yet to be implemented. Much cross-fertilization took place, since different countries and localities are trying different solutions to similar problems or are at different stages of execution. In addition to the Conference's three plenaries and 15 concurrent sessions, participants took advantage of the time reserved between sessions for informal discussions. Two evening receptions held in conjunction with the Conference facilitated informal meetings as well.

This Conference marked the first time many of the reform practitioners from around the NIS had participated in a voluntary association of health professionals, without central direction, where they were free to exchange technical

information and views. Few, if any, of the participants received an official mandate on the content or delivery of their presentations. Establishing the precedent of a professional meeting with open technical exchanges represents an accomplishment in its own right. 🌐



At the ZdravReform Regional Technical Conference, counterparts share lessons learned in implementing health reform experiments.

ZdravReform Director Dr. Nancy Pielemeier (left) and Karakol Site Manager Dean Millsagle (second from left) meet with Kyrgyzstani delegation to the ZdravReform Regional Technical Conference.



## L'viv Survey Shows Positive Attitude Toward Private Medicine

Results are in from one of the first surveys ever undertaken in the NIS of physician attitudes toward, and involvement in, the practice of private medicine. *ZdravReform* and its counterparts in L'viv, Ukraine, conducted the survey last November and December, and initial findings confirm what most observers have long suspected: "Private medicine" is being practiced informally, *na levo* (literally, "on the left"), involving both large numbers of government physicians and substantial, unreported fees paid by patients for supposedly free services. Survey results indicate there is widespread acceptance of private medicine among physicians and the public and imply that conditions, at least in western Ukraine, are considerably more favorable for the expansion of private medicine than previously thought. Less clear is what impact a growing private health sector will have on the overall state of medicine in Ukraine (or elsewhere in the NIS) and on the public's health.

*ZdravReform* completed the survey, which involved 325 physicians from L'viv oblast, in collaboration with the Department of Health Administration at L'viv Medical School. Co-principal investigators Peter Hauslohner, Ph.D., senior technical advisor from Abt Associates Inc., and Yaroslav Bazylevich, M.D., from L'viv Medical School jointly designed the survey, wrote the questionnaires, supervised

execution of the project, and analyzed the results. The L'viv Marketing Group, an experienced local survey research firm headed by Mr. Serhiy Hrubiy, interviewed physicians and collected data. Fifty-two officially licensed private health care providers (individual physicians and companies) in L'viv oblast and 273 physicians practicing at government clinics and hospitals in L'viv city responded to the survey. According to Hauslohner, the survey may be the first of its kind undertaken in the NIS.

The survey asked state physicians what percentage of "their colleagues" accept payment from patients and how much they earn each month. Those in the survey replied that, on average, 40 percent of public sector physicians take fees which may total as much as \$86 per month per physician. If these figures are right, physicians working in L'viv earn \$1.6 million per year, and city residents pay them more than \$2 per capita per year (see box).

Official license-holders were understandably more reluctant to answer analogous questions. Nevertheless, survey results suggest that while private physicians practicing openly probably earn considerably more in fees on average than state physicians—perhaps 10 times more—the small number of such physicians means that total receipts among all licensed providers in L'viv oblast may be as low as \$300,000 per year, or \$0.11 per capita paid by oblast residents.

Although the prevalence of informal private medicine comes as no surprise to most observers—indeed, local experts thought the calculated figures were too small and that real earnings are two or three times higher—the implications are hard to overlook. Clearly, private medicine is widely accepted by health care professionals and the public alike. Over half of the state physicians surveyed (52 percent) said private medicine should be "encouraged," and nearly half (46 percent) said it should at least be legally "permitted," while only three respondents (1 percent) thought it should be "discouraged" or "forbidden."

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Dr. Borys Uspenskiy, *ZdravReform*/L'viv technical adviser, and Dr. Yaroslav Bazylevich, L'viv Medical University, review survey results.



## L'viv Survey: Methodology and Early Analysis

The *ZdravReform*-sponsored survey interviewed 325 respondents drawn from two groups: officially licensed private providers of health care services in L'viv oblast and state physicians in L'viv city.

**License-holders:** The Ministry of Health of Ukraine supplied a computer printout listing 341 individuals and firms in L'viv oblast that had been granted licenses to provide health services from 1991, when licensing began, through July 1, 1995. However, many addresses were incomplete or incorrect, and many of the other listed persons/firms said they had never practiced. As a result, interviewers obtained only 52 completed responses, and 40 percent (21) respondents indicated they were not practicing private medicine at the time of the survey.

**State physicians:** A total of 250 physicians was randomly selected from 24 state facilities located in L'viv city, yielding a proportional sample of 6 percent of all state physicians practicing there. The chief or deputy chief physician from each facility was interviewed as well. In sum, interviewers collected 273 completed responses, including a subgroup of 30 senior managers.

The questionnaire administered to "official" private providers consisted of 62 questions, many with multiple responses, and took 45-60 minutes to complete. The questionnaire given to state physicians consisted of 39 questions—in most cases the same questions asked of license-holders—and took 30-40 minutes to complete. Respondents stated their views on a variety of policy reform options and aspects of their medical practices, as well as their attitudes toward, and involvement in, private medicine. Interviews also collected background information on the respondents.

Analysis of the data so far has focused on inspection of summary statistics and comparisons between license-holders and state physicians. It has not yet examined differences between senior managers and other physicians, as well as among physicians based on differences in their age, gender, years of experience, and medical specialty.

One of the most important findings to date pertains to the estimated size of the private market for health services. State physicians estimated the percentage of their "friends and colleagues" who regularly receive payments from patients. More than 80 percent responded, and the mean answer was 39 percent. Respondents then were asked how much physicians who accept fees earn each month. Nearly half (46 percent) said less than \$50 per month; 18 percent said between \$50 and \$100; 12 percent said between \$100 and \$200; 3 percent said between \$200 and \$500; and 2 percent said more than \$500. Assuming respondents based their answers on personal experience and that the real distribution of earnings mirrors these answers—i.e., if 46 percent of those who accept payment receive on average \$25 per month, if 18 percent receive on average \$75 per month, etc.—then the figures imply that the average fee-earning state physician in L'viv receives \$86 per month. If 39 percent of all state physicians in L'viv in fact receive payment, earning an average \$86 per month, total annual payments exceed \$1.6 million, or \$2.06 per city resident. (License-holders were asked analogous questions, although a smaller percentage—50 percent—responded. A similar method was applied to these answers and resulted in the figures cited in the accompanying article.)

A summary of survey results and discussion of the main implications for policy are in a draft report, *The Future of Private Medicine in L'viv Oblast and in Ukraine: Findings and Recommendations*, available in English and Ukrainian. The final version of this document is due in late June. A full account of the survey project—including background on organization, description, and preliminary analysis of the main findings, summary statistics for each question, and copies of the two survey instruments—is likewise expected in late June.



# Experiments in Quality Yield Visible Changes in Russia

## Quality Updates

□ .....  
The City Hospital of Novosibirsk is only one of 14 Russian health facilities working on Continuous Quality Improvement with the *ZdravReform* Program. Five hospitals established projects in early 1996 to improve the processes of care delivery so that infection rates for medical-surgical patients and complications for routine births decrease from the 1994 baseline.

□ .....  
An inter-oblast Coordinating Committee of senior Siberian physicians defined and began implementation of 12 principal ambulatory care quality indicators; 30 polyclinic leaders attended a seminar to introduce the indicators.

□ .....  
In central Russia, Tver oblast health leaders established a Quality Council. Also in Tver, Stanley J. Tillinghast, M.D. and Medical Director for *ZdravReform*/Russia gave a seminar on utilization management.

□ .....  
Tillinghast is working with the *ZdravReform* Regional Director for Central Asia to plan a conference on evidence-based medical practice for fall 1996. He also is working on developing a partnership between the Russian Medical Association and the American Medical Association.

- One- and two-bed patient rooms, sparkling clean and decorated with plants and flowers.
- Patient satisfaction questionnaires.
- An intensive care unit with operational medical equipment.
- “Fishbone” diagrams to identify cause and effect in the process of care.

### Features of a typical hospital?

Not necessarily, if you are in the former Soviet Union, where drab patient rooms often house eight to 10 persons, hygiene is lacking, equipment and supplies are nonexistent, and quality means a physician who follows a detailed procedural protocol—with little concern for bedside manner.

Stanley J. Tillinghast, M.D. and Medical Director for *ZdravReform*/Russia, recently visited the City Hospital in Novosibirsk, Altai Krai. Prior to his visit he feared having to use only Western examples to demonstrate modern Continuous Quality Improvement (CQI). The Novosibirsk hospital visit proved otherwise. Altai Krai health care quality experts have participated in *ZdravReform* study tours to the United States and now are implementing CQI techniques learned during the tours in their own hospitals.

During a recent tour of the Novosibirsk hospital, Tillinghast viewed changes resulting from CQI experiments implemented by Chief Doctor Leonid Litvinenko and his two quality experts. Upon entering the hospital, he noticed signs directing incoming patients to the registration area, and later he admired walls painted with peaceful murals and wards decorated with flowers—and a television.

In an interview with one patient, Tillinghast learned that she chose to travel to Novosibirsk rather than have surgery in Barnaul, the oblast capital. “Novosibirsk has surgeons who specialize in the surgery I needed. Not only am I pleased with the surgery, but the staff treats me like a friend; the food is great; the rooms are clean.” A second patient smiled and nodded in agreement, and a third opined, “As far as I’m concerned, Moscow is the provinces, and Novosibirsk is the metropolis, in terms of health care.”

According to the chief nurse “when we get a complaint, the patient is always right.” *ZdravReform*-trained

**Patients relax in the comfortably-appointed waiting room/solarium at the City Hospital of Novosibirsk**



## ZdravReform Staff Changes

**On June 1, Dr. John (Jack) Langerbrunner, Senior Health Economist for the ZdravReform Program, will become Country Director for ZdravReform/Russia. Langerbrunner has spent an extensive amount of time in Russia in the past two years. Departing the position is Dr.**

**James Rice, who will join The Governance Institute in La Jolla, California.**

**Also on June 1, Dr. Marty Mäkinen, ZdravReform Technical Deputy, will become Regional Director for ZdravReform/West NIS, replacing Dr. Marc Stone, who will assume duties at Abt Associates, Inc./Bethesda.**

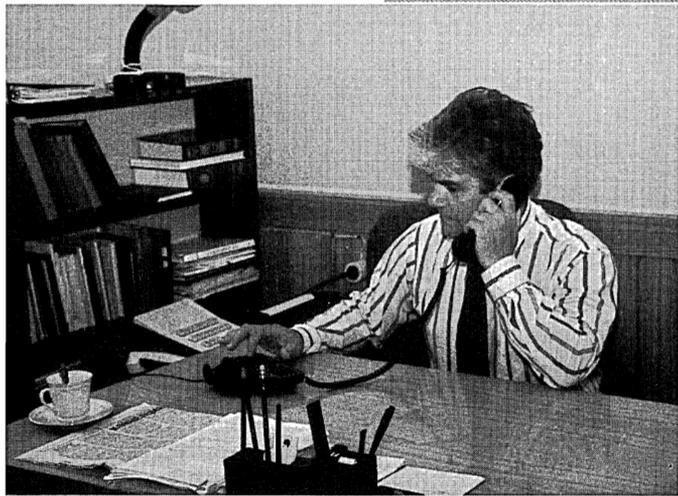
quality expert and Altai Krai Deputy Director for Licensing and Accreditation Dr. Tatiana Ivanovna Drachova adds, "the hospital distributes questionnaires to patients and asks them to respond anonymously. [If they get a complaint,] they find out what the problem is, so they can improve it."

Other stops on the tour revealed other reasons for optimism: a large and pleasant staff cafeteria, a conference room where all physicians meet once a week and a library where, during Tillinghast's visit, books on political ideology were being removed to make room for medical literature.

Reform efforts in Novoaltaisk did not begin with Tillinghast's visit, nor are they limited to nonclinical aspects of care. Dr. Dewees Brown, a ZdravReform primary care consultant who visited the hospital, cautioned that the hospital's equipment is outdated by global standards, but admitted that "it's far and above better than [other facilities in Russia]." ZdravReform consultant Peter Wilson, who provided assistance in bed typology, called it "a well managed, well functioning organization...committed to community service."

Dr. Litvinenko, who studied economics and management as well as medicine, has in the past decade cut the average length of stay from 24 to 9.5 days. "I am convinced that there is plenty of money in the Russian health care system if we just get rid of waste. We can easily close 30 percent of our hospital beds with no problems whatsoever."

Litvinenko has put together a young and highly dedicated corps of physicians. No department chief is older than 40. Physicians are paid according to the quality and productivity of their work. Those unwilling to meet his standards have left the staff. Those who remain have higher morale and the respect and love of their patients. In turn, they revere their chief. Responding to a leading comment from a ZdravReform interpreter who also has been Litvinenko's patient, one nurse said, "Perhaps he can be brusque at times, but we love him anyway, because of what he's done for the hospital."



**Dr. Leonid Litvinenko, chief doctor of City Hospital of Novoaltaisk**

Drachova, a surgeon, has developed for the hospital Ishikawa fishbone diagrams to demonstrate the components of patient care: physician treatment, nursing, pharmacy, equipment, physical plant, etc. She also helps the hospital's two quality experts to anticipate potential problems with giving proper patient treatment and encourages all concerned staff to become involved in devising solutions.

The hospital, like the rest of the Russian health care system, must continue to work to meet world-class standards. It must deal with general economic constraints and implement further efficiencies. It must work with equipment that, while operational, is decades of out of date and develop reliable procurement of pharmaceuticals, to stock a pharmacy located in what was once a bomb-shelter.

But Tillinghast leaves the hospital pleased to have found a concrete example that Russians, with a little help from ZdravReform, some economic incentives and lots of their own energy, creativity and common sense, can provide caring, quality medicine. 🌐



### Marketing Team Activities

1. Meeting with the Family Group Practice Association to establish FGP image and logo;
2. Designing and testing campaign messages, which were distributed through information sheets and brochures;
3. Producing and distributing promotional items including pins, pens, T-shirts, and plastic bags.
4. Participating in health promotion activities, such as Immunization Day, when they distributed colorbooks on FGP and information about AIDS prevention for the Center to Fight AIDS;
5. Working with the mass media (newspaper, television, and radio);
6. Disseminating information about campaign goals through enterprises, schools, and public fora;
7. Disseminating campaign messages through an information booth at the main market in Karakol and through a door-to-door campaign in Washod and Kaska-Su (areas within Karakol);

## Consumer Choice Campaign in Kyrgyzstan Enrolls 86 Percent of Karakol Population in FGPs

by Bakyt Akmatov, Svetlana Asankhodzaeva, Alisher Ibragimov, Lena Sturova (the Karakol Marketing Group)

Eighty-six percent of citizens of Karakol city, Kyrgyzstan, recently enrolled in 16 newly created family group practices (FGPs) developed and marketed with the assistance of the *ZdravReform* Program. Even higher percentages enrolled in other areas of Issyk-Kul Oblast where FGPs have been established: In Tyup rayon, 92 percent of the population with access to six new FGPs enrolled.

The Karakol enrollment period, May 20-25, was the culmination of an eight-month consumer choice campaign led by the Karakol Marketing Group, with assistance from *ZdravReform* staff, FGP physicians and managers, and community volunteers from the Karakol Management Institute, local schools, and other community organizations. It signified the first-ever opportunity in Kyrgyzstan for consumers to choose where they would seek medical care.

The marketing group, with the assistance of Courtney Roberts, *ZdravReform* Information Dissemination

Bus displays announcement about FGPs.

Specialist, designed the marketing campaign to introduce the concepts of family medicine and free choice of physicians, and to encourage enrollment in FGPs. These FGPs will provide primary care services to the entire population, and thus help to correct the inefficiencies of a health system formerly based on more expensive inpatient care. By the end of 1996, it is expected that 81 FGPs will be operational throughout the oblast. These FGPs will be fundholders (i.e., receive a specified amount of money to pay for all the health services required by their enrollees), with the amount of money each FGP receives based on the total number of their enrollees.

The marketing team started the campaign in July 1995 and in the ensuing months carried out a staged process of educational and promotional activities (see sidebars).

In January 1996, the marketing team conducted a pilot enrollment campaign in Dzhety-Oguz rayon. The pilot campaign, during which 72 percent of the population of Kaska-Su, a village in Dzhety-Oguz, enrolled, covered the first



Karakol schoolgirl shows off FGP colorbook.



four FGPs set up in Issyk-Kul Oblast and enabled the marketing team to test the impact of their activities and better plan for the Karakol and Tyup rayon campaign. The pilot campaign demonstrated the necessity of working more closely with physicians on educating the population and of involving the community. From February to May, the physicians actively conducted public outreach activities, and the team planned a series of community-based events for the enrollment period in Karakol and Tyup rayon.

Newly hired family practice managers were central in campaign implementation. In March, the marketing group trained the family practice managers to participate in the campaign. Then, managers held meetings in areas around Karakol, at enterprises and schools, and assisted in conducting focus groups. During the enrollment period, they managed day-to-day operations at the enrollment sites and reported daily campaign progress. Results from nearly 50 focus groups helped the team plan events and enrollment site locations which would be accepted by the population.

Taking the needs of the population into consideration, the team organized eight enrollment sites around

Karakol and four sites in Tyup rayon. At the enrollment sites, which were open to the public from 7 a.m. to 5 p.m., there were sporting events including karate demonstrations and volleyball and basketball competitions, and concerts by local musicians and folk song and dance groups. In addition, FGP managers organized sales of medication and refreshments.

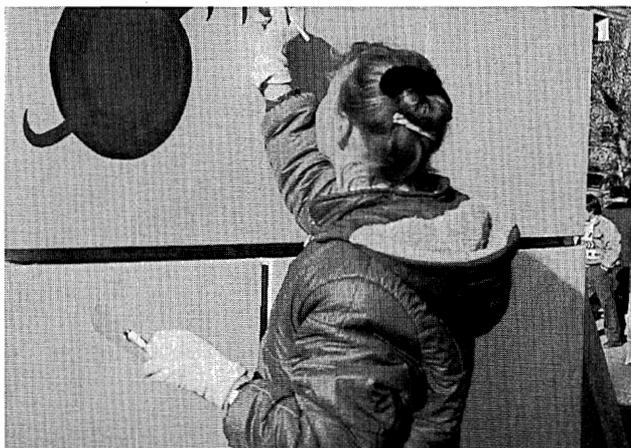
Exit interviews conducted during the enrollment period revealed that consumers took seriously the opportunity to choose FGPs. They carefully read through information sheets written about physicians in each FGP, and consulted with their family members before they enrolled. One enrollee at the Children's Polyclinic enrollment point said he had never before seen so many people interested in medical services. "With the implementation of the FGPs, there is a change in mindset. Not only do the physicians have a role in better health, but also the patients themselves."

Physicians also viewed the organization of FGPs as a revolutionary step in the process of health reform. One physician in

8. Posting printed materials in shop windows and at pharmacies;
9. Placing FGP advertisements on Karakol buses;
10. Designing and replacing monthly an information bulletin board at the Central Polyclinic;
11. Holding drawing and writing contests at elementary schools on medical themes, following teacher presentations about FGPs;
12. Conducting seminars with physicians and volunteers to prepare them to participate in the enrollment campaign;
13. Planning the enrollment period activities.

Karakol resident reads FGP information brochure.

Artist/architect Lena Sturova paints FGP logo on information booth.



Santarsh, a village in Tyup rayon, said that with the implementation of FGPs, physicians "will feel more responsibility for patients. Before we paid attention mostly to patients with chronic diseases, and now all the patients are our responsibility." The physicians also expressed relief that nurses and managers in their practices would be responsible for duties such as accounting and patient intakes, thus freeing up more time for them to spend on patient needs.

In Santarsh, where 93 percent of the population enrolled in the first day of the campaign, the internist gave

the following advice: "To my colleagues in other countries, don't be afraid to try a new thing. If there are difficulties, [you] will overcome them with hard work and perseverance."

Additional FGPs are expected to open in Tyup, Ak-Su, and Dzhety-Oguz rayons at the end of June, and the marketing group will continue enrollment campaign activities there. In December 1996, Karakol citizens will have the opportunity to change FGPs during an open enrollment period. 

### Russian Health Care Reform

(Continued from page 2)

They made 30 percent of MHI payments to medical facilities (Territorial MHI Funds directly transferred 70 percent of payments), while insurance companies manage no reimbursement.

- MHI spending in 1994 finally focused on its primary objective: allocations to medical facilities, which increased from 27.5 percent of total MHI Fund outlays in 1993 to 74.6 percent in 1994. Sixty-seven Funds had claim reimbursement systems set up and in regular operation.
- Administrative overhead was kept in check, accounting for no more than 1.4 percent of the Federal MHI expenditure and 2.8 percent of the territorial outlays. Interpretation of such fine numbers may be a matter of definition. For example, if training, insurance research, and investment income taxes were classified as overhead, another 12.9 percentage points would be added to the Federal MHI Fund's overhead. At any rate, the predominantly monopsonistic structure of the territorial health insurance markets in Russia makes the system potentially efficient in terms of administrative costs. If administrative activities are focused on efficient utilization of care, they will pay off in lower spending on medical services.
- An across-the-board tendency is to overaccumulate reserves. Needless to say, all MHI Funds are tempted by the availability of highly profitable financial instruments for institutional investments. To their

credit, however, it should be noted that hedging against inflation remains a legitimate concern and in a highly volatile economy like Russia's such hedging may result in all kinds of "creative" investment initiatives on the part of the MHI Funds.

- The per-patient discharge method of paying hospitals reportedly now dominates the MHI system, while outpatient providers are still paid through annual global budgets, unrelated to performance. Overall, health insurance innovation has so far not translated into efficiency gains in health service delivery. A significant reform goal thus remains unaddressed and is eroding. Once the economy improves, the health sector may experience rapid cost growth in the absence of cost-containment measures.

*Implications of the Russian experience for NIS health care reforms.* In Kazakhstan the mandatory health insurance began nationwide implementation in 1995, and in Kyrgyzstan it will take effect in 1997. In both countries the legal framework clearly resembles the Russian model. In Ukraine and Moldova intensive health policy deliberations are underway, and other NIS countries are at different stages on the continuum of health reform policy development. While overall, health care reforms have not begun in most parts of the former USSR, several countries are on the brink of decisions that will determine the future path of their health care systems. It is not too late for reform leaders to consider the vast range of options that remain available to them and to avoid obvious mistakes.

After 3.5 years of trailblazing experience with MHI, Russia has a lot to say to those countries which are



currently exploring similar mechanisms and wish to develop a balanced and comprehensive health reform agenda.

In summary, the Russian experience suggests the following: First, MHI should not be considered as the only or the main health care reform issue. Second, any attempt to reform the health care sector is bound to fail unless it appeals directly to providers and consumers of services, the primary stakeholders in the system. Third, creating a new source of funding that requires setting up a parallel system of administration leads to increased administrative confusion and methodological incongruity that may outweigh gains from new health insurance premiums. Fourth, to the extent that conflicts may arise between the old (MOH-affiliated) and the new (MHI-affiliated) health bureaucracies, dominance will go to the party who takes over as the methodological command center of the reforms, i.e. will identify truly relevant issues and collaborate with the medical profession, employers, and consumers to reach comprehensive solutions. Fifth, reforms must not give way to bureaucratic logic (see the previous item). The Oblast Health Administrations and Territorial MHI Funds may operate under a common administrative umbrella and deal as partners with non-overlapping regulatory functions (see below).

#### *The Role of the MHI*

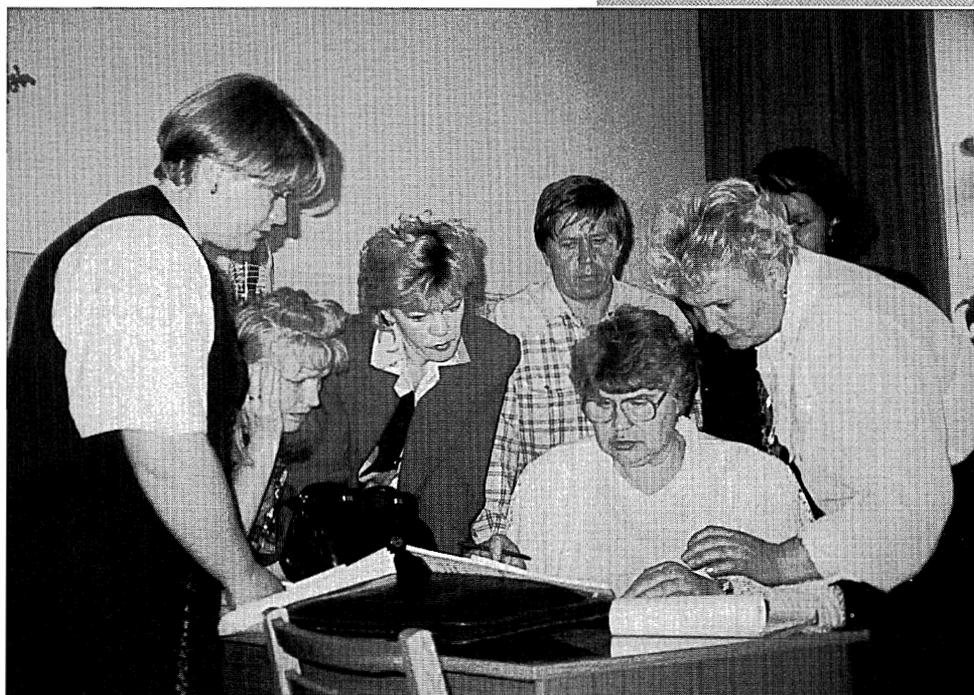
**Fund.** The MHI Funds and the Oblast Health Administrations may establish themselves in an MHI-driven environment and at the same time avoid disruption in the health care sector that could result from conflicts.

It would be a mistake for the Federal and Oblast MHI Funds to focus too narrowly on their monetary functions, trying to outmaneuver the MOH on its traditional turf. A long time may elapse before the MOH agrees in good faith to pool the health budget

Hospital managers learn ZdravReform designed tools for financial management during course in Novosibirsk.

with MHI insurance premiums. Until this occurs, the MOH will retain financial power, and chief doctors will continue to view the MOH as a legitimate purchasing authority. Furthermore, even if funds flow through the funds, as long as the Funds limit their role to collecting premiums and allocating them to providers in the same way as the MOH has done in the past, the MHI system will be politically vulnerable and unprotected. The MOH will wonder: What is the rationale for the MHIF if the Ministry can collect premiums from employers and utilize this additional source of funding without paying additional overhead costs necessary to maintain the Funds network?

To earn its right to exist, the MHI network will have to establish itself by introducing radically new approaches to paying providers for their services. No matter how limited the amount of reimbursement is initially, the Funds should seriously consider introducing payment methods that would bring about incentives for providers, freedom of choice for consumers, and accountability and transparency in the health care system for group subscribers and regulators. The following choices are worth strategic consideration: creating integrated delivery systems, granting them broad autonomy and comprehensive fundholding status, reimbursing their costs, based on a prospectively paid full capitation rate. These approaches will appeal to



providers, and the Funds will get credit for their proactive attitudes, professional competence, and general sense of leadership. Building their own political base among health care providers, consumers, and employers initially as a methodological leader in the health care system, the MHI Funds will then become influential enough to take over a major part of the national health budget, if so mandated by national MHI legislation.

***The Role of the MOH.*** Deregulation as the fundamental principle of health care reform should not be mistaken for the erosion of the governments' regulatory power in the health care sector. In fact, the regulatory functions of the policy center will be extended to new, previously neglected areas. The MOH and the oblast health departments will keep in check the intensity of the structural shift in the health care sector in order to prevent disruptions in the delivery of services and ensure fair play conditions—time for adjustment—for relatively non-competitive facilities. Governments will monitor market-driven restructuring and prevent monopolistic collusion. Case-by-case decisions will be made to protect certain facilities and physician practices from bankruptcy if no alternative source of care exists. The MOH will play an important role in licensing and accreditation, developing outcome-based quality control systems, technology assessment, drug formularies, patient registration, and clinical coding databases. In a broader quest for methodological leadership, the MOH would take the lead in developing: (1) sample contracts and regulation of relationships among providers of care; (2) clinical classification lists for rate schedules; and (3) guidelines for facility rationalization and cost recovery.

The MOH may significantly contribute to facilitating professional and economic adjustment of displaced health personnel, perhaps even manage a national database that would help to match excess labor with job openings. Another innovative function to consider is designing clinical and operational profiles of new types of facilities, e.g. outpatient surgery centers, subacute care centers, nursing homes, hospices. These are likely to emerge in a market-driven process of

optimizing the delivery system. The MOH will have the opportunity to assume even more functions, which will stem the overall liberalization of relationships between providers and consumers of health services, e.g. redress of consumer grievances and conflicts among providers; organization and co-sponsoring of malpractice insurance. (Some of the above-listed functions could be shared with the MHIF.)

***Health Policy Reform Strategy: an Integrative View.*** Health care reform should not boil down to the introduction of health insurance. Instead, it should cover a broad array of issues that would enable comprehensive internal restructuring of the health care sector. A major paradigm shift is necessary from a command-and-control system of health administration to a self-regulated environment based on autonomy for providers of care; incentive-based methods of resource allocation and reimbursement of services; consumer choice of primary care physicians; managed competition; and cost-containment—enhanced through full fundholding, nonitemized budgeting, deregulation of the health sector's labor management practices, and quality assurance by clinical outcomes rather than through restrictive, normative-style micromanagement of clinical practice.

From a policymaker's perspective, reliance on the self-regulatory potential of the medical profession and the health care sector should be viewed as a politically beneficial approach to health care reform. Decisions on closing redundant hospitals and removing excess personnel will be generated internally; only viable facilities will be able to compete for contracts from the fundholders, while the cost-inefficient and/or quality-ineffective ones will be phased out of the marketplace by means of self-policing contractual and accreditation mechanisms. Empowered with economic incentives and exposed to financial risks, the medical profession will self-regulate in favor of the structural adjustment in the provider network and rationalization of health facilities. Government responsibility for politically unpopular decisions, inherent in centrally administered health care reform, will be reduced. ☪

# Development of a Managed Care Pilot Program in Odessa, Ukraine: *The Odessa Medical Alternative*

In March 1996, the Family Health Center (FHC) in Odessa, Ukraine initiated a pre-paid managed care pilot program called the Odessa Medical Alternative (OMA). Under OMA, the FHC provides unlimited access to FHC health services, including consultations, laboratory tests, and treatment ordered by FHC physicians, in exchange for a fixed monthly or annual fee. The plan is designed primarily for enterprises to purchase affordable health care for their employees and employees' families. The FHC enrolled its first group, totaling 200 individuals, in March and began providing care to them in April. When fully implemented in late 1996, the managed care program is expected to benefit patients, enterprises, and the FHC. Patients will gain access to high quality health care. Enterprises and other member organizations will provide health care at an affordable and fixed price. The FHC will expand its patient base and diversify and stabilize its funding sources while reducing the costs of providing health care services.

As mentioned in the first issue of *Vital Signs*, the FHC is a private polyclinic that funds operations entirely from patients' payments, one of very few health facilities in Ukraine to do so. Established in 1991, it provides a range of health services to an average of 400 paying patients per day. Its general medicine and pediatrics departments will form the core of the managed care program.

The FHC was selected as the site for the managed care experiment because of its willingness to take risks and its progressive management. In spite of these qualifications, OMA will be a challenge. Under its traditional fee-for-service payment method, the FHC can compensate for increased costs of providing services by raising fees to patients. Each patient visit means increased revenue. In contrast, under the pre-paid plan, increased costs must be absorbed by the FHC, and additional patient visits mean lower revenue per visit. Hence, on the management side, the FHC will need to closely monitor OMA costs and utilization rates. On the care side, it will have to modify its traditional approach of responding to health care problems to one of keeping patients healthy through an increased emphasis on preventive care.

Director Dr. Valentina Bespoyasnaya and other FHC staff designed OMA in collaboration with *ZdravReform* consultants Hopkins Holmberg and Katherine Westover. They produced a detailed business plan, a

technical report and several working papers discussing information system requirements, clinical records, sales strategy, and system documents such as a sample membership agreement.

Bespoyasnaya assumed responsibility for sales of OMA to employers, and she worked with enterprises to tailor the plan to their specific needs before finalizing a contract.

During the past year, *ZdravReform* provided the FHC a computer programmer and an accounting specialist to develop a computerized management information system to track enrollment, diagnoses, services provided, and revenue collected from patients as well as a backup system for the data base. More recently, the programmer refined the system to meet the information needs of OMA and to print patient record folders and member photo identification cards. *ZdravReform* consultants also helped to develop, test, and refine the forms used for collecting the information that is later entered into the computer.

OMA's business plan calls for it to start on a small scale and expand gradually, giving the FHC time to solidify its experience in providing care under a managed care approach and test its expectations regarding the utilization of services. Once management is comfortable with the new administrative and information systems and physicians have adjusted their methods of providing care to the new incentive system, the FHC will become more aggressive in recruiting additional organizations into the OMA program.

*ZdravReform* consultant Holmberg will return to Odessa in August to evaluate the OMA experiment, recommend changes where appropriate, document lessons learned, and present his findings in a seminar. In the meantime, *ZdravReform/Odessa* will continue to provide assistance with implementing the pilot, and Holmberg will develop a manual on how to implement a small scale managed care program. The manual is expected to be ready for distribution in fall 1996.

Managers of several other health facilities in Odessa have requested *ZdravReform* assistance to develop similar managed care programs in their facilities. Pending approval of *ZdravReform/Ukraine's* revised workplan, the program will provide such assistance to at least two additional facilities in Odessa. 

## L'viv Survey on Private Medicine

(Continued from page 4)

Although definitive answers regarding public attitudes will have to await the results of analogous research, it is apparent that, just as many state physicians accept fees “on the side” from their patients, many patients are likewise willing to pay for “free” services.

Why? According to local experts, some patients pay to obtain needed medicines or the use of scarce, modern equipment. Others pay to guarantee treatment by the “best” physicians. Still others pay simply to ensure attention from otherwise inattentive health care providers.

It also is evident that patients may be prepared to spend a lot more if prices were to fall and/or if they could get more information about, and exert more control over, health care providers. In other words, both financial and attitudinal conditions are much more favorable for the expansion of private medicine than previously thought.

But how to promote its growth? The survey asked both state physicians and license-holders to evaluate and compare problems faced by would-be private providers, and their answers were similar. The most serious problems, both groups agreed, are: obtaining financing, overcoming “legal-bureaucratic” obstacles, and taxation. Problems not regarded as especially serious are: attracting patients and obtaining necessary supplies of medicines and equipment. The only major disagreement between the two groups concerned the “Mafia,” which was viewed as a far more daunting obstacle by state physicians than by license-holders. It is tempting to speculate, in this connection, that successful entrepreneurs operating in current conditions in the NIS learn to accommodate organized crime and treat it as just another cost of doing business.

Yet, lowering or removing the obstacles facing private providers may not be enough. Abt's Hauslohner argues that as long as government promises more public services than it can actually afford in practice—thereby fueling excess demand and shortages—and most of the funding that supports health care is reserved for state providers protected from competition, state principals will find easier, less expensive, and more profitable to remain in the public sector and to practice private medicine informally. An informal private medicine is not “all bad,” Hauslohner points out. “It helps increase the total amount

of funding for health care, which, in turn, raises the incomes of physicians and the amount of service delivered to patients.” But informal private medicine is “economically inefficient, and, of course, very little of the revenue gets re-invested, on account of the lack of ownership rights.” Just as important, he adds, private medicine practiced *na levo* “weakens popular respect for the law, and it probably increases social inequalities, by diverting resources away from patients too poor to pay and from basic health services, in favor of more affluent patients and more exotic, expensive, but medically less necessary services like cosmetic surgery.”

Hauslohner believes the growth of private medicine will remain stunted until the advantages afforded state physicians are reduced. To achieve this, two reforms are particularly important. First, the government needs to develop a minimum package of services that it can afford to provide free-of-charge to all citizens. Then, it must make it clear that the public should expect all other services to be provided on a for-fee basis, whether the provider is private or public. Second, the government should make it possible for private physicians and companies to compete on a level playing field with government providers for the right to deliver publicly-mandated services—and to receive the public financing to pay for them.

Private medicine is by no means a cure for all of the ills afflicting Ukrainian medicine, says Bazylevich. Moreover, as the private sector expands, its effects on the public's access to, and use of, health care services, as well as on health outcomes, will need to be followed carefully. Bazylevich is already thinking about how to study patient attitudes and behavior and says he would welcome continued collaboration with the *ZdravReform* Program. In the meantime, he and other local experts agree that the growth of private medicine can help (1) mobilize additional funding for health, (2) increase the efficiency and effectiveness with which available resources are used, (3) improve the quality of many services, and (4) perhaps stem the outflow from medicine of young, skilled, ambitious specialists who are seeking not only more money but also greater professional autonomy than the public sector presently offers.

“Health is the most precious value of all,” says Bazylevich, “and most people view very positively the opportunity to choose freely one's physician and the idea that high quality services should be paid for.” 



# List of Newly Available Publications (as of 5/1/96)

## Central Asia

- CAR-4 Trip to Kazakstan and Kyrgyzstan, July 24-August 1, 1995, by John S. Tilney, Jr.
- CAR-5 Deputy Director for Operations Trip to Central Asia, Almaty and Shymkent, Kazakstan and Issyk-kul Oblast, Kyrgyzstan, September 30-October 14, 1995, by Richard Killian.
- CAR/KAZ-18 Participant Training for Madame S. Barakhova and Ms. G. Shim, SKO Kazakstan, June 6-June 16, 1995, by Barbara Burgess.
- CAR/KAZ-19 Organizational Development of the National Mandatory Health Insurance Fund and the Phosphorus HMO in SKO, Shymkent, Kazakstan, November 26-December 20, 1995, By George P. Purvis III.
- CAR/KAZ-20 Developing Roll-out of Provider Payment Reforms in Kazakstan under the New Insurance Reforms Initiative, February 11-24, 1996, by Jack Lagenbrunner.
- CAR/KYR-14 Technical Assistance for the Issyk-kul Oblast Health Insurance Demonstration: Capitation Rate Setting and Financial Modeling, May 21-June 11, 1995, by Edward C. King, Actuarial Research Corporation.
- CAR/KYR-15 Health Facility Licensing and Accreditation and Family Group Practice and Mandatory Health Insurance Fund Update in Issyk-kul Oblast, Karakol, Kyrgyzstan, January 22-February 16, 1996, by George P. Purvis III.

## TECHNICAL NOTES (TN) AND TECHNICAL REPORTS(TR)

- TR NIS-1 Regional Technical Conference Report, March 1996, by Marty Makinen.
- TR CAR/KAZ-1 South Kazakstan Oblast Health Demand Survey Results by John Novak, January 1996.
- TR UKR-6 L'viv Intensive Demonstration Site. A Tool Kit for Implementing User Fees and Decentralized Management Accounting Systems in City Hospital No.1 (L'viv, Ukraine) by Annemarie Wouters. November 1995.
- TR UKR-7 Internal Control and Cash Management Manual and Questionnaires. L'viv, Ukraine. by Bradford C. Else, November 1995.
- TR UKR-8 Institutionalizing Improved Cost Management and Internal Control Systems and Reviving User Fees at Polyclinic No.2 in L'viv, Ukraine, by Bradford C. Else, November 1995.
- TR UKR-9 Self-financing and Cost Recovery in Odessa, Ukraine, by Abdo Yazbeck, Tim Metarko and Tom Wittenberg, January 1996.
- TR UKR-10 Design of Managed Care Prepayment Program for the Family Health Center in Odessa, Ukraine, by Kate Westover and Hopkins Holmberg, January 1996.
- TN UKR-1 Preliminary Analysis of Service Delivery Restructuring and Other Health Reform Initiatives in L'viv (Skole Rayon), Ukraine, by Marty Makinen, October 1995. (Ukrainian)

## West NIS

- WESTNIS-1 Health Management Training in Moldova and Ukraine and Health System Development in Rezina District, Moldova and Zhovkva Rayon, Ukraine, February 23-April 3, 1996, by George P. Purvis, III, Hopkins Holmberg, and John B. Stevens.

## UPDATES

West NIS Updates are available for the months of October and November 1995, December 1995/ January 1996, and February, March and April 1996.

## Ukraine

- UKR-21 Technical Assistance to Skole Rayon, November 7-22, 1995, by Marty Makinen.
- UKR-22 L'viv Intensive Demonstration Site : Implementing User Fees and related Management Accounting Systems, October 14-November 5, by Annemarie Wouters and Brad Else.
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