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**THE ALMATY EXPERIMENT
WITH FUNDHOLDING POLYCLINICS AND FAMILY
GROUP PRACTICES: PREPARATORY STAGE**

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Almaty, Kazakstan**

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1. BACKGROUND

The Almaty Experiment was conceived at the end of 1996, after a prolonged period of weighing out pros and cons of conducting a pilot project in such a politically complex milieu as the capital city of Kazakhstan. The experiment is intended to increase physician productivity, improve cost-efficiency, strengthen primary services and continuity of care, broaden consumer rights, and upgrade provider satisfaction. Polyclinic-based fund holding was selected to be a universal lever for a coordinated advancement towards the above stated challenging set of goals. More specifically, two city polyclinics will set up family group practices (FGPs), which will be transferred on partial prospective capitation and will be granted certain management autonomy rights. FGPs will compete with one another and non-participating area-serving internists and pediatricians. Open enrolment will bring to the front-stage such tools of competition as technical and perceived quality of services. Financial incentives inherent in prospective capitation will drive primary physicians towards higher cost efficiency. Altogether, health care and resources will start shifting towards primary services, causing shrinkage of resources in specialized outpatient care and, longer term, in emergency and hospital facilities. Such shifts will lead to health gains and, at the same time, will increase cost-efficiency and financial sustainability of the health care sector. Cost-containment structural adjustment will occur both at the facility level and system-wide.

Telyukov became initially involved in the preparation of the Almaty experiment in February 1997. At that time the conceptualization stage of the project was not yet complete. The consultant was assigned to conduct a round of policy discussions and assessments in order to identify and evaluate as follows: (1) institutional capacity to carry out the experiment, particularly, presence of pro-reform leadership at the designated pilot polyclinics ## 2 and 7; (2) degree of concurrence among the main stakeholders on any particular model of fund holding, or, alternatively, degree of preference for a multi-tier approach; (3) how closely fund-holding FGPs should be tied to the paternal polyclinics; (4) degree of preparedness of the designated facilities to the experiment, e.g. their operational and financial profile, integration of children's population into the catchment areas of formerly adult polyclinics.

A policy design workshop and a series of follow-up conversations with prospective participants led to a number of conclusions:

- Chief doctors (ChDs) of the pilot polyclinics have a mixed motivation with respect to fund holding. They would welcome the innovation as an opportunity to improve financial status of their facilities. However, they showed a rather non-committal attitudes towards such issues as polyclinic's restructuring, divestiture of redundant resources, and granting broad autonomy to family group practices, implicitly required by the capitation method of financing.

- While ChDs are ambiguous in their attitudes towards FGPs' autonomy, prospective members of FGPs are likely to split into two categories. A larger number would prefer to stay on polyclinic's payroll and operate as family practitioners under the polyclinic's auspices, thus avoiding business risks of running an independent practice. Very few, however, would prefer to opt out of the polyclinic and register as an independent solo or group practice.
- The experiment lacks legal basis: its key mechanisms, including capitated funding, will clash with the existing over-regulated environment in health financing. For the experiment to succeed, it needs to be officially endorsed and excluded from a variety of rules and procedures, currently restricting operations of health care providers in Kazakhstan.

In February 1997, Telyukov recommended to conduct the experiment in two tiers: (1) to set up FGPs, largely, within the polyclinics; (2) to give the right to the most risk-taking primary doctors to become legally independent practitioners. Such approach was accepted by the counterparts as accommodating various motivations, encountered among prospective participants to the experiment. In early March, the consultant wrote draft concept of the experiment, elaborating on both models. He also drafted an executive order to be signed by the Mayor of Almaty, authorizing the experiment and related innovations. Both documents were made available to the ZRP/CAR office and the Almaty counterparts.

2. OBJECTIVES

Upon arrival in Almaty, Telyukov was assigned by Dr. M.Borowitz, the ZRP/CAR Regional Director, to perform the following work:

- 1) Amend the experiment outline so as to merge two scenarios into a single scenario. The experiment should focus on polyclinic-based fund-holding FGPs, similar to Scenario 1 in Telyukov's concept. Unlike that scenario, however, FGPs will enjoy flexibility in choosing referral providers of specialty and paraclinical services. They will have an option of outsourcing specialty services. In response to competition with FGPs' external sub-contractors, and prospectively lower workload in the polyclinic-based specialist offices and diagnostic departments, the polyclinic will have to restructure itself. Under the scenario, proposed by Dr. Borowitz, restructuring will be more unavoidable, than in the originally proposed scenario 1, where it seem to be left more at the ChD's discretion.
- 2) Consolidate institutional environment: hold discussions with the City of Almaty Health Administration (CAHA), the participating polyclinics' ChDs, the Mayor's office, the RK and the City MHI Fund. The purpose of such discussions is as follows: (i) elicit stronger political support and advocacy for the experiment from main regulatory and purchasing agencies; (ii) explain the essence of the revised, single-model approach; (iii) broaden institutional base of the experiment by inviting the RK MHI Fund to sponsor, or otherwise facilitate it.

3) Set a more consistent framework for capitated rate estimation. The designers of the experiment draw on budget neutral approach. It is not clear, however, what benchmark should be used to assess the base line level of financing. CAHA, the City of Almaty MHI Fund, and the RK MHI Fund do not concur in their views of the current level of per capita outpatient spending, nor how much funding may be afforded for experimental polyclinics by way of preferential treatment.

3. WORK AND FINDINGS

3.1 Concept of the Almaty Experiment

Telyukov wrote a concept of the Almaty experiment, refocusing its prototype version from a dual- to single-scenario approach. The full Russian text of the concept is enclosed with this report (see Annex 1). Below are detailed highlights.

3.1.1 Goals

The experiment is intended to contribute to the following health care reform goals: (i) strengthen primary care; (ii) increase continuity of services; (iii) broaden consumer rights; (iv) improve professional and economic satisfaction of health care providers; (v) increase cost-efficiency, thus making the health care sector more financially sustainable.

3.1.2 Program and Contents

The City Polyclinics ## 2 and 7 will become fund-holding institutions operating on capitated funding. The City of Almaty MHI Fund will be the main or the sole purchaser of the polyclinics' services (through out the discussion in this section, please, use *Chart 1* for graphical reference).

The base line capitation rate will be related to the actual per capita spending on outpatient care in Almaty. The precise amount of capitation will be negotiated by the polyclinics with the MHI Fund. Capitation rate will include services routinely provided in outpatient settings. However, the payor and provider of services may consider inclusion of selected emergency- and hospital-substituting services, as well. Extensions to outpatient capitation rate should be validated through a careful evaluation of the actual ability of the polyclinics to provide those services with adequate quality. During the experiment the capitation rate will be adjusted for age/sex composition of enrolled populations.

Recurrent funding will be prepaid to polyclinics by monthly installments. The monthly budget is a product of *per month per member* (PMPM) rate, times number of enrollees. The polyclinics, thus, become *partial fund holders*. The term *partial* implies in this context that only outpatient services are involved in capitated funding. As other services

become gradually integrated in the capitation rate, partial fund holding will evolve into *full fund holding*.

In order to make a better use of their money, polyclinics will arrange for *internal fund holding*. To that end, *family group practices* (FGPs) will be set up within the polyclinics. First FGPs (two per polyclinic) will be staffed, predominantly, with primary care physicians, retrained under the UK Know-How Fund project. All area-serving internists, pediatricians, and gynecologists/obstetricians will have the right to join in an FGP. Each FGP will be accredited to practice family medicine by the experiment's Supervisory Board (see below). Besides primary care doctors, every FGP will include nurses. FGPs' personnel number and composition will be determined at FGPs' discretion.

Each FGP will have a separate enrollment pool. At the outset of the experiment, enrollment will be established as the sum of enrollments in each member-doctor's traditional catchment area. Over the course of the experiment, open enrollment will be introduced, putting FGPs at competition for the population. FGPs will compete with one another for both adult and children's populations. In addition to that, they will compete with non-member internists for adult population and with pediatricians for children's population.

Polyclinic will allocate funding to FGPs and non-member primary care physicians according to enrollment size. Competition for the patients will be tantamount to competition for financing.

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The FGP capitated budget will be allocated along three lines of spending: (1) To pay rents to the polyclinic, including administrative overheads and housekeeping costs; (2) To cover FGP's own costs of providing primary services; (3) To pay for referrals to specialists and paraclinical services.

Rents (facility-wide costs) will be withheld by the polyclinic from the FGP budget on a monthly basis, as a fixed percent of the FGP budget. Such percent rate will be determined by means of cost flow analysis, negotiated between the FGP and the polyclinic administration, and locked for one year.

An FGP will right off its own operating costs, and will pay providers of specialty and paraclinical services based on a fee-for-service method of reimbursement, i.e. per procedure, doctor/physician contact, and/or otherwise defined unit of service. Fee schedule will be geared to the polyclinic budget constraint, as negotiated with the payor. Fee schedule and techniques of its periodical revision will be designed at the early stage of the experiment.

FGPs are entitled to purchasing specialized and paraclinical services both within and without their polyclinic. The polyclinic chief doctor will assist FGPs with identifying the most effective and efficient subcontractors. The polyclinic will negotiate and sign contracts with participating providers on FGPs' behalf. Centralized procurement of services for the polyclinic-based FGPs will facilitate volume discounts, thus, minimizing the overall cost of outsourcing.

Fund-holding polyclinics and FGPs alike will be granted broad autonomy in shaping and managing their budgets. The following new opportunities of improving their financial status will emerge with this respect: *Firstly*, good reputation in the eyes of the local residents will allow successful fund holders to increase enrollment and, consequently, get more revenue through capitated funding. This will lead to increased salaries, even if the share of salaries in the FGP reimbursement is held constant. *Secondly*, the budgets of competitive FGPs will grow not only because of increased enrollment, but also because primary doctors will assume greater clinical responsibilities, thus, referring fewer patients to specialists and diagnostic services and retaining a larger part of their budget for internal allocations. The process of shifting care and financing to primary services will intensify when emergency and hospital care becomes subject to capitation along with outpatient care. *Thirdly*, FGPs will have more authority in deciding how to allocate their revenue by cost category. By combining the inputs of production in ways, that producers themselves consider optimal, the system as a whole is expected to gain in cost-efficiency.

Once in every half a year, chief doctors (managers) of FGPs operating on the financial surplus side, will present for approval of the polyclinic's ChD, a plan of spending savings on bonuses, material, and miscellaneous needs of their FGPs.

Importantly, financial and professional autonomy of fund-holding FGPs will be growing hand in hand. As professional qualifications and skills of primary care physicians increase, so will their role in forming health maintenance strategies and techniques. FGPs will increasingly influence and optimize the entire continuum of health care delivery. They will change utilization and referral patterns, adjust management and financing

rules, that regulate FGPs operations, and their sub-contractors; introduce better systems of quality control and performance evaluation; establish modern management information systems, to serve the above listed goals. FGPs will favor interdisciplinary approach to their self-management: they will increasingly draw on professional advice from managers, financiers, lawyers. As FGPs strengthen their financial capabilities, they would start hiring financing/operations managers on a full-time basis. FGPs will become comprehensive promoters of modern management tools, encouraging their implementation health system-wide.

The economic risks will grow in symmetry with the economic opportunity. This refers to fund-holding polyclinics in general, and FGPs, in particular. The opportunities will derive from the fund holder's right to retain savings, achieved by means of clinical and management rationalization. The risks are associated with the possibility of insolvency due to over-spending and shrinking enrollment. Cost inefficiency and poor quality of services will be equally detrimental for a polyclinic's and an FGP's sustainability.

Fund-holding polyclinics will enter into contractual relationships with other health care facilities. Provider contracts would set forth a projected range and volume of care (number of referrals by FGP and type of service), payment rates, criteria of clinical appropriateness, means of quality control, and terms of outlier reimbursement.

Payor/Provider contract will be signed between the City MHI Fund and/or other major payor, on the one hand, and the fund-holding polyclinic, on the other. The principal provisions of the contract will be enrollment size, range of capitated services, and capitation rate. Other terms and conditions may include list of services to be reimbursed independently from capitation funding, criteria of clinical appropriateness and utilization standards for high volume services, procedures of quality control, open enrollment, redress of consumer complaints.

Consumer rights will be among the experiment's prime targets. The main right, that of choosing primary care physician, will be ensured by means of open enrollment. Open enrollment periods will be announced annually and will last for one month. *Family* enrollment will be encouraged. However, at the initial stage of the experiment, established catchment areas by internist, pediatrician, and polyclinic-wide will remain intact. By the end of 1997 (or approximately six months upon the beginning of the experiment) patients will have an opportunity to choose among the polyclinic-based doctors. The residents of contiguous areas will have preferential right of enrollment.

Open enrollment may lead to a significant redistribution of the polyclinic's budget across FGPs. The most attractive for consumers FGPs would drive the least competitive ones out of business by taking over their share in the total capitated budget. The polyclinic administration may establish workload thresholds, as a numerical benchmark to decide, whether and when a contract with an ineffective FGP should be discontinued. For example, it may be set forth in the contract that if the FGP fails to ensure enrollment of more than 80 percent of its capacity, the polyclinic may decline to host such physician practice.

Free consumer choice should not be misinterpreted as a completely random choice. The patient and his/her family do freely choose the source of primary care. As part of such choice, however, they sign up to a limited number of referral providers of specialty and diagnostic services, i.e. specialty physician practices, health, and diagnostic centers with which a preferred FGP has contracts. Also, patient behavior will be restricted from the standpoint of his/her moving across levels of care. The experiment will examine the possibility of co-payments for self-referrals to specialty services, i.e. bypassing the primary care doctor. Non-network referrals may also be restricted by imposing cap on their reimbursement at a certain percentage of customary and usual costs.

3.1.3 Evolution of the Polyclinics

The above described mechanism implies that the polyclinic will remain an integrated medical and economic entity. The ChD authority will not be challenged by the fund holding.

At the same time, the experiment will urge the ChD to embark on internal restructuring of the polyclinic. In planning his/her budget, the ChD will have to make adjustments for increased clinical capacity and workload of FGPs and other primary care doctors. Annual salaries, physical plant, and operating material costs of FGPs are likely to grow. Conversely, utilization of specialty and paraclinical services would decline, because of lower referral rates and outsourcing. To maintain specialist offices and diagnostic departments at low occupancy, becomes unaffordable since part of their recurrent budgets is now promised to FGPs.

In order to preempt the emergence of a financial gap within the polyclinic budget, the ChD will start cutting down on specialty care resources. The ChD may institute an Advisory Board to guide the polyclinic through structural rationalization. Key clinicians both from FGPs and specialty departments, as well as external consultants will sit on the Board, identifying structurally-depressed areas and developing and implementing a transition plan to get rid of those. A variety of cost recovery tools will be used, to keep the polyclinic break-even under rapidly changing supply/demand conditions; (i) part of the personnel will be laid-off; (ii) some nurses will be transferred on time-sharing schedules and will shift around various physician offices and diagnostic departments in order to match the workload peaks and lows; (iii) redundant equipment will be sold out, and liquidation revenue will accrue to the polyclinic's budget; (iv) excessive space will be rented out (perhaps, to independent FGPs); (v) seasonal variations in utilization will be levelled off by setting up summer camps on the polyclinic's premises, and by engaging temporarily unoccupied space and personnel into other non-medical activities.

The ChD will become preoccupied with how to reduce administrative overheads. To that end, (i) administrative departments will be streamlined in order to phase out duplication of functions; (ii) productivity of administrative personnel will be increased by introducing computer-assisted management information systems; (iii) by solving more in favor of outsourcing, the make/buy dilemma in arranging for management support.

Creation of new departments and services will become an important direction of a polyclinic's restructuring. As a fund holder, the polyclinic will try to increase capitation rate by extending its license to additional services. E.g., the ChD will feel motivated to cut into hospital services by starting up day surgery center and enhancing post-admission rehabilitative care, including outreach services. By diversifying into and increasingly competing for emergency- and hospital-substituting services, the polyclinic will be evolving into a full fund holder, seeking to gain dominance on the local health care market.

3.1.4 A Long Term Outlook: Independent FGPs

The experiment entails strong potential for driving a longer-term evolution of the Almaty health care system. As the most viable FGPs gain experience and become confident that they can assume greater business risks, they would be able to opt out of the polyclinic and register as independent legal entities.

Free-standing FGPs will rent or buy offices of their own, taking advantage of tax incentives and preferential rent/utility rates that exist in Almaty for sole proprietors and small businesses, engaged in provision of *socially relevant* services. Alternatively, independent FGPs will become tenants at their *parental* polyclinic.

Independent FGPs will enter into *direct* contractual relationships with a purchasing authority, such as the City of Almaty MHI Fund. Prospectively paid capitated funding will accrue to an FGP's own banking account. The FGP will directly contract secondary and tertiary care out to selected providers. If FGP prefers to deal with its parental polyclinic on the provision of specialty services, the parties will negotiate terms and conditions of care provision and will set them forth in a contract.

If polyclinics (where unit costs are potentially higher because of relatively high overheads) delay structural rationalization (e.g., as described in *section 3.1.2*), they may be priced out of the market. The best specialists, lab technicians, and health personnel in other relevant occupations will quit polyclinic in order to start up their own offices and offer their services at a more competitive rate to fund-holding FGPs. Price competition, driven by independent fund-holding FGPs will intensify erosion of the polyclinics in their current configuration.

3.1.5 Expected Outcomes and Implications

It is expected that the experiment will strengthen mechanisms, contributing to the national health care reform goals, as proposed in *section 3.1.1*.

FGPs will turn primary care into the key element of health care delivery system and the dominant power in allocating resources to providers of secondary and tertiary services. Financial incentives inherent in fund holding will shift emphasis on prevention, early detection and treatment of diseases. As partial fund holding evolves into full fund holding, clinical and organizational strategies of primary care physicians will translate

into lower hospital admission rates and reduced length of stay, development of new services, changes in organizational formats of delivering traditional services, with the general focus on cost containment.

Primary care physicians will gradually extend their professional and financial control to all levels of care, in order to achieve strategic alignment of secondary and tertiary service providers by the FGPs' own strategies of maintaining health in general, and preventing, diagnosing and treating particular diseases. By becoming a centerpiece element of professional and financial responsibility in the health care sector, FGPs will make the entire system more accountable and transparent for the regulatory center, the payor, and the patient alike.

Fund-holding polyclinics and, longer term, independent FGPs will become catalysts of cost-containment structural rationalization in the health care sector. The polyclinics will begin with restructuring themselves. It is likely, that large ambulatory facilities will downsize and disintegrate into a number of primary care physician and specialist offices, and also smaller diagnostic centers, offering services at more competitive rates. As polyclinics shrink, the least competitive part of health personnel will be displaced.

Incentives of fund holding will motivate primary care doctors to *work* longer hours. FGPs' financial and management autonomy will allow doctors to *earn* more, since their remuneration will closely correlate with their effort. Higher earnings and greater clinical responsibilities, and decision-making powers will upgrade economic status of primary care physicians and will strengthen their professional dignity. Demand for family medicine as an area of specialization in medical training, will grow. This will allow schools of medicine to unfold full-fledged curricula of training in family medicine, and make admission process more competitive.

Under capitated funding consumers will gain in their rights. The money now follows the patient: enrollment size defines the fund holders' budgets. The experiment will help health care reforms reach their main beneficiary – the patient. Extensive social marketing campaign should become an integral part of the experiment in order to educate residents of the experimental areas about their new rights, facilitate their informed choice, and encourage prudent behavior (not to over-utilize, and to recognize the gate-keeper's role of the primary care doctor).

In a reformed health care system, CAHA will play multiple regulatory roles. It will focus on non-financial regulations, including such new functions as: (i) credentialing of fund-holding organizations, (ii) development of clinical appropriateness criteria, (iii) design of drug formularies; (iv) quality control; (v) facilitation of structural change, particularly, retraining, reallocation and job placement of displaced personnel; (vi) mediation in negotiations between purchasing authorities and fund holders, and among fund holders and referral providers.

The MHI Fund, as the main payor, will play the key financial roles in the experiment. It will take the lead on the following activities: (i) rate setting work at all levels of resource allocation; (ii) cross-sectional cost analyses to compare efficiency of various fund-holding systems (polyclinics and their referral providers); (iii) control of patient and

money flows; (iv) supervision of competitive contracting process among fund-holding polyclinics and sub-contracting facilities; (v) pro-competitive interventions whenever the most competitive fund holders may grow into local monopolists.

Needless to say, the experiment's limited scope will allow to make but a limited advancement towards the above described status of the health care system. However, the leaders of the experiment will work to ensure a *coordinated* progress towards the *entire* range of stated objectives and outcomes.

3.1.6 Preparatory Work

To enable the experiment, the following preparatory steps are recommended:

- 1) A Supervisory Board will be formed to coordinate inputs to the experiment by CAHA, Mayor's Office, City MHI Fund, RK MHI Fund, experimental polyclinics, key referral providers, and concerned grassroots and consumer organizations.
- 2) Primary care physicians, currently being trained under the UK Know-How Fund project, will group into FGPs. They will decide freely who to work with. The number of doctors per FGP will not be regulated, except from the standpoint of an FGP's self-sufficiency and manageability. Simply put, FGPs should not be either too small or too big.
- 3) Each FGP will be informed of the experiment's goals, objectives, program, and expected outcomes, and how those will impact on the doctors' rights and responsibilities. Primary care physicians will be trained in financial incentives underlying the fund holding, and on the risks and opportunities that those incentives create for FGPs. Expected changes in clinical strategies, referral patterns, and operations will be explained to the doctors, to guide them towards optimal performance.
- 4) Each FGP will be accredited on a provisional basis. If the range of services, which they are allowed to provide, deviates from the array of services for which pilot polyclinics have been originally licensed, additional services will be detailed in accreditation certificate.
- 5) The payor(s) will be identified. In particular, the RK MHI Fund's willingness to support the experiment with funding will be assessed through intensive discussions with the Fund's directorship. If the National Fund chooses to stay away from the experiment, the sponsorship will be sought at the City level.
- 6) An executive decree will be drafted, to be signed by the Mayor of Almaty. It will be discussed by the main stake-holding institutions and presented to the Mayor's Office. The main purpose of the document is to officially endorse the experiment and exempt it from financial and operational restrictions, that remain in place in the health care sector, being incompatible with capitated method of provider reimbursement and deriving incentives.

- 7) Capitation rates will be set in tentative terms, based on various interpretations of budget neutral approach. Enrollment will be projected. Importantly, as of April 1997, children's population, though, reportedly, already integrated into the polyclinic's catchment areas, has not been included by the polyclinics in their 1997 projected enrollment. It remains to be seen, therefore, if mixed catchment areas have been actually created for experimental facilities.
- 8) The payor/provider contract will be drafted and submitted to both parties for review and negotiations.
- 9) Pilot polyclinics will identify their main referral providers.
- 10) Intensive costing and rate-setting work will be conducted both at the polyclinics and referral providers, to estimate unit costs on major services and develop fee schedules.
- 11) Provider (polyclinic/sub-contractor) contracts will be drafted and negotiated, specifying volumes of services, some basic utilization and quality standards, and payment rates.
- 12) As the experiment gets underway, quality control, management information, and evaluation systems will be designed and put in place. By the end of 1997, rules and procedures relating to open enrollment, budget management, and structural rationalization will be adopted by fund holding polyclinics.

3.2 Assessment of Capitation Rates

A variety of issues needs to be addressed while setting capitation rates for the pilot polyclinics: (1) What kind of benchmark should be used for budget neutral assessment? (2) In the worst case scenario: how much below the current per capita spending may 1997 capitation rate shrink, to avoid disruption of the experiment? (3) How much in excess of the actual level of funding would it be appropriate to solicit, should institutional support turn out to be more favorable than expected? (4) What would be a reasonable way to split the estimated capitation rate among various payors, should more than one purchasing institution offer financial support for the experiment?

An optimally estimated capitation rate should be the product of a coordinated response to all the above listed questions.

3.2.1 Polyclinic # 7

For a comparable enrollment size – reported 39,718 persons in 1996 and projected 39,765 persons in 1997 – the annual financing in 1996 is just 70 percent of the projected 1997 amount. Clearly, both years are budgeted on a different scale: the 1997 budget appears to be significantly higher, largely, because it was adjusted for inflation. Consequently, the base line should be geared to the 1997 numbers.

The 1997 outlook shows large variations on a month-to-month basis (see *Table 1*). The projections seem to allow for seasonal fluctuations in demand. Another factor must be

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general volatility in MHI-based health financing. The RK MHI Fund policy is to trim disbursements in line with collected premiums. Since compliance is unstable, so is insurance reimbursement.

In summary, monthly average funding projected for 1997 is KZT 49.79 per month per member. This is 20 percent below the annual peak of KZT 59.75 reported for January and February. Discussions with Dr. Kabikenova and Mr. Zakharov, CAHA's Deputy Directors, and Dr. Smagulova, the Polyclinic # 7 Chief Physician led to the conclusion that January/February-based PMPM rates will be closer to objective need than projected 1997 monthly average. January and February funding covered all cost categories: an unusually favorable occurrence in a dramatically underfunded health care sector of Kazakhstan.

3.2.2 Polyclinic # 2

The above described calculations have been performed on the Polyclinic # 2 numbers as well (Table 2).

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3.2.3 Summary Assessment

Mr. Zakharov in concurrence with both ChDs made further important insight by suggesting that, if at least KZT 49.79 PMPM rate is pushed through for Polyclinic #7 and, correspondingly, KZT 53.48 for Polyclinic # 2, “everybody will feel happy”.

In search of more reference points for an accurate *triangulation* of the capitation rate, the consultant went to the RK MHI Fund and spoke with Ms. Khafiza Uteulina, Head of the Medical-Economic Administration. Ms. Uteulina provided additional important benchmark for the capitation rate calculation. She said that 1997 MHI budget for outpatient services in Almaty is planned at KZT 600,000,000. For a 1.2 million population this translates into KZT 41.67 PMPM rate. This rate is just 83.4 percent of what was planned in annual terms for Polyclinic # 7 and 77.9 percent for Polyclinic # 2.

It will take the MHI system’s good will, to provide funding at the above discussed preferential rates. While the RK MHI Fund is still hesitant whether to acknowledge the experiment (as of April 13th, 1997), the City MHI Fund’s director Dr. Gulshara Urmurzina made a clear and strong statement in its support. However, with all her willingness to admit the experiment under her auspices, she had to make her support contingent upon the Mayor’s preparedness to revise his Ordinance # 54 of February 5th, 1997.

The document rules that the entire amount of on-budget contributions for MHI, scheduled for 1997, must be obligated for inpatient care. If all these monies end up locked in the hospitals, the Almaty inpatient budget will amount to KZT 1,270,000, or 68 percent of the total in- and outpatient health care expenditure. With ambulatory care, limited to just 32 percent, it will be difficult for the City MHI Fund to make any significant redistributions in favor of pilot polyclinics. Dr. Urmurzina’s legitimate request is to leave it at the City MHI Fund’s discretion, how to allocate government contributions for MHI. She believes, that for partial fund holding to succeed, at least 40 percent of the entire health spending should be capitated and allocated to fund-holding polyclinics and standalone FGPs. She expressed commitment to contribute to outpatient financing from employers’ premiums, by matching allocations from on-budget funds.

If employer/government contributions are reallocated to outpatient services on a proportionate basis, that is according to their 1997 projected shares in the City MHI Fund’s aggregate spending, funding may be shifted as follows:

To increase the share of outpatient services from 32 to 40 percent, additional KZT 148 million will have to be allocated to ambulatory facilities. Of that amount, KZT 76 million will be raised from employer premiums, and KZT 72 million from on-budget premiums. A modest 11.7 percent of the City MHI Fund outlays will suffice to accomplish this structural transformation. From the standpoint of the experiment, such shift alone will easily accommodate the Polyclinics’ ## 7 and 2 annual financing, both its baseline and incremental parts. As derives from *Tables 1* and *2*, the two polyclinics’ projected budgets will amount to KZT 51,640,000 if based on the year average PMPM rates of respectively KZT 49.79 and KZT 53.48; and to KZT 61,968,000 if based on the year-average PMPM rates of KZT 59.75 and KZT 64.18. Under the first and second scenarios, the share of

experimental polyclinics in the Almaty outpatient health care budget will be 8.6 percent and 8.3 percent, respectively. Therefore, the scope of the experimental financing, will be too limited to jeopardize stability of the city health care budget.

Chart 2 provides a descriptive/numerical summary of alternative options in setting the capitation rates and budgets of the pilot polyclinics.

TRIP ACTIVITIES:

April 7th: (1) Discussion with Dr. Michael Borowitz, ZRP/CAR Regional Director. Subject: Preferred model for the polyclinic-based fund holding in Almaty; (2) Visit to the National MHI Fund: Discussions with Mr. Imanbayev, Fund's Director. Agenda: Priorities of further technical assistance to the Fund; Polyclinic Restructuring; Training seminars: subjects and timing; (3) Meeting with Chief Doctors of the City Polyclinics ## 2 and 7, designated as pilot sites for the Almaty experiment;

April 8th: (1) Meeting at the City of Almaty Health Administration. Subject: Evaluation of the political and financing environment, underlying the Almaty experiment; basic features of the recommended model; (2) Work on the Concept of the Almaty Experiment and Draft Decree of the Almaty Mayor, intended to endorse the experiment; (4) Telephone discussion with Mr. E. Sidorenko, MIS Expert, Zhezkazgan Oblast MHI Fund. Subject: Data pre-processing for iterative modeling of an outlier reimbursement formula for Zhezkazgan hospitals.

April 9th: (1) Revised Concept of the Experiment was submitted to the National MHI Fund; (2) Meeting with Dr. Urmurzina, Director of the City of Almaty MHI Fund. Agenda: Environmental assessment of the Almaty experiment from the standpoint of the City MHI Fund's policies and financial capabilities; (3) Development of overheads for the upcoming meeting at the National MHI Fund; (4) Meeting at the National MHI Fund. Agenda: Prospects for the Fund's participation in the Almaty Experiment.

April 10th: (1) Drafting Payor/Provider Contract at the request of the National MHI Fund; (2) Meeting with Mr. Suleimenov, Deputy Mayor of the City of Almaty in charge of the social service sectors. Purpose: recruiting the Mayor's office for support of the experiment.

April 11th: (1) Finished Draft Payor/Provider Contract for the National MHI Fund and experimental polyclinics; (2) Submitted the document to the Fund and discussed it on a preliminary basis with key mid-level executives; (3) Met with the Polyclinic # 7 Chief Doctor and received statistics of 1996 financing in aggregate and by cost category; (4) Held telephone discussions with Mr. Suleimenov, the Deputy Mayor of Almaty. Subject: a possibility for the ZRP team to meet with the Mayor to present the concept of the experiment; (5) Talked on the phone with Dr. Raushan Kabikenova, Deputy Health Administrator of Almaty, discussing alternative approaches to setting partial capitation rate for experimental polyclinics.

April 12-13th: Worked on trip report and in preparation for the Monday meeting at the RK MHI Fund.