



ZdravReform
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Health Care Financing and Structural Rationalization in Uzbekistan

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SUMMARY

ZdravReform consultant Alexander Telyukov visited Tashkent, Uzbekistan for a 12-day consultancy. The purpose of the trip was to (1) participate in a policy planning workshop focusing on the issues of structural rationalization in the national and regional health care sectors, (2) clarify the fund flow profile of the Uzbekistani health care sector by level of public spending, and (3) address current technical assistance needs and help identify priorities for ZRP work in Uzbekistan in 1998.

The seminar resulted in consensus that structural change is imminent and should be planned for, regardless, even, of the SVP (rural health post) need for operating funding. Attendees concurred that it would be in the best interest of the national health care sector to eliminate the most obvious redundancies in personnel and physical plant and concentrate what limited funding is available on the viable part of the resource base. As it became clear during the seminar, the political situation has lately become more favorable for structural reforms. At least three regulatory documents contributed to the creation of a more dynamic environment in the national health policy. The contents and implications of those documents are summarized in the Section 4.1.1 of this report.

In a nutshell, the government sets out the following structural changes:

- *Service Mix* to shift care from inpatient to outpatient,
- *Finance Mix* to shift public health financing to user fees and employer-based financing to local budgets by means of earmarked tax on corporate net profits, and
- *Ownership Status* to change the ownership status of selected public health care facilities by means of privatization and transfer company-based health care services to municipal ownership.

The common thread of the mandated changes is to increase financial sustainability in both public and non-public segments of the national health care sector. How far the government is prepared to go to deregulate the health care sector, in order to increase the motivational base for the announced changes, remains to be seen. It is likely that at least some shift will occur towards more autonomous decision making and cost recovery on the oblast and facility levels. Such change might set a somewhat more favorable stage for structural adjustment and elimination of the SVP financial gap.

The upcoming changes in the national health policy may be considered as a potential contributing force to structural rationalization plans, central to the World Bank Loan Project. The government, clearly, will not pave the whole way to deregulation or structural reforms. At best, it will become more receptive to the oblast-level initiatives.

Also, the new government decrees give a new spin to the issue of SVP financial sustainability. Thus far, four strategies for closing the SVP financial gap could be considered: (1) A resource-saving structural shift within the publicly funded health care sector and allocation of savings to the SVP operating funding; (2) Stretching the SVP implementation schedule over a period of longer than four years; (3) A downward revision of SVP recurrent cost; (4) Gradual integration of employer-funded facilities into the oblast structural rationalization plan. This would spread the change over a larger resource base and make it less intensive for publicly funded facilities. Alternatively, if

employers become reluctant to downsize their health care network, the government could charge the industry a 'solidarity' tax earmarked for SVP operations

Strategies (1) and (4) aim to increase the supply of resources while (2) and (3) intend to reduce the demand for resources generated by SVPs operating needs. The new government initiatives may strengthen the *supply-side* approach to closing the SVP financial gap. (i) The extension of user charges to hospital meals is tantamount to the introduction of a new source of health care funding. Importantly in the SVP context, the government encourages the territorial Health Care Administrations to strengthen primary services by using appropriately the savings from partial transfer of meals cost to user fees. (ii) Transfer of company-based clinics to municipal ownership enables the local governments to apply restructuring to a much broader resource base, thus making it less radical and intensive. As a result, the range of tools that may be used in closing the SVP financing gap becomes more diversified.

The initial promise of change, suggested by government's new regulations and the counterparts' more advanced thinking, is yet to be developed into an effective policy action and sustainable implementation. Eight lines of technical assistance are recommended to make structural reforms happen.

- 1 To assist the experimental oblasts with building and evaluating a more comprehensive list of structural reforms, consistent with the SVP program targets and time frame, and mindful of existing political constraints
- 2 To develop a case-based 'master plan' of facility rationalization with modifications for urban hospital, polyclinic, and rural health care network anchored in a central rayon hospital. Such a plan should be presented in a how-to manual and detailed into a step-by-step blueprint. A decision-making tree will institute a significant part of the algorithm, relating strategies and techniques of restructuring to a facility clinical and resource utilization profile, local health care market structure, and local socio-economic and political environment. A facility-level *rationalization plan* will be supplemented with the oblast-level component. The latter will detail functions and activities that should be carried out by the local fiscal, labor, and health care authorities.
- 3 To assist with a downward revision of the SVP operating budgets. In order to close the SVP financing gap in full, structural change will have to exceed the levels and intensity dictated by rationalization of the health care network. To prevent restructuring from becoming 'irrationally' radical, the counterparts and the WB alike will have to consent to a 'residual' financing gap to be filled by methods other than rationalization. One such method is a downward re-estimation of the SVP recurrent cost.
- 4 To identify the list of issues that require reconciliatory adjustment in or exemption from the existing legislation and to propose appropriate amendments. The legal waiver issue may be resolved by making appropriate amendments in pertinent bylaws, or by proposing a presidential decree that would legalize the experiment and key experimental mechanisms, thus taking precedence over the existing regulations. The latter 'block' approach may be preferred to the

former 'itemized' approach, since it spares the effort of dealing with multiple pieces of regulations that would require revisions

- 5 To assist with preparation of a health financing reform that has been maturing in Uzbekistan for the past two years and is expected to start in 1998 with system design and legislative work. The *ZdravReform* Program may have a rare opportunity to influence the legislative process in Uzbekistan right from its inception. Technical assistance may begin with a five-day interactive policy workshop and be followed with a feasibility study of the new health financing mix, writing a White Paper of Health Financing Reform in Uzbekistan, and drafting and a national Health Financing Reform Law
- 6 To assist with ownership reforms in the health care sector. An initial offer of help may include development of not-for-profit legal status and drafting a pertinent national law on NGOs, market valuation of facility assets (for property redemption or simply for accounting purposes), preparation of a package of legal documents for facility incorporation, design of a master business plan and guidelines for its customization to various clinical and business needs and conditions, market research to estimate market potential for designated types of care, training of counterparts in operations and financial management of health facilities, development of policy and contractual guidelines for purchasing authorities to incorporate non-public health care facilities into a unified competitive market of medical services
- 7 To assist key health policy and financing agencies in their current reform work, including help to the State Committee for Forecasting and Statistics (*Goskomprognozstat*) with preparing 20-year Long-Range Forecast and 10-year Mid-Term Outlook for the health care sector, collaboration with the Ministry of Finance on analyzing the outcomes of the national health facility survey [*inventarization*] conducted in 1997, assistance to the *Goskomprognozstat* with revising the program of household budget survey to improve reporting on user health care spending, help to the Ministry of Health on methodological and statistical development of prospective capitation
- 8 To strengthen domestic expertise in health care financing and administration. Several laconic yet potentially effective ways are recommended for *ZdravReform* to inform the professional community of Uzbekistan of the needs of the national health care sector and reforms

TABLE OF CONTENTS

SUMMARY	1
TABLE OF CONTENTS	4
1 BACKGROUND	5
2 OBJECTIVES	6
2 1 Objective A Policy Planning Workshops	6
2 2 Objective B Fund Flow Profile	7
3 ACTIVITIES	8
3 1 Seminars	8
3.2 Technical Assistance	8
4 FINDINGS	11
4 1 SVP Financing Gap and Structural Reforms	11
4 1 1 National Policy Guidelines	11
4 1 2 Fergana Oblast	15
4 1 3 Syrdaria Oblast	16
4 1 4 Navoi Oblast	18
4 1 5 Preliminary Evaluation of the Proposed Plans	18
4 2 Fund Allocation by Level of Budgetary System the Case of Fergana Oblast	19
4 2 1 Central Budget	19
4 2 2 Local Budgets	19
4 2 3 Fund Allocation Process	19
4 2 4 Fund Disbursement Process	20
4 2 5 Budget Planning Cycle and Provider Payment Innovation	20
5 CONCLUSIONS AND RECOMMENDATIONS	21
6 REFERENCES	26
6 1 Activity Log	26
6 2 List of Key Contacts	27
7 ANNEXES	28
ANNEX 1 Fund-flow analysis a review of methodology	28
ANNEX 2 Parameters of SVP Financing Gap and Structural Adjustment Nov 1997	32
ANNEX 3 Resource Analysis (in Russian)	36

1. BACKGROUND

The *ZdravReform* Program (ZRP) is expected to continue the work of the World Bank (WB)/Uzbekistan Health Sector Loan Project. The focus of the technical assistance (TA) component of the project, which began in November 1996 and will conclude in December 1997, was as follows: (1) to estimate SVP (the local acronym for rural health posts) needs for physical resources, information, and training, (2) to assess sustainability of operating financing of the SVPs, and (3) to develop a clinical plan and guidelines for effective SVP operation. According to the presidential decree¹, over 800 SVPs will open in Uzbekistan from 1996 to 2001. The WB is considering a loan to the government of Uzbekistan to fund capital investment for building some new SVPs and remodeling others from existing facilities. The Fergana, Navoi and Syrdaria oblasts are experimental sites under the WB loan project. They are expected to demonstrate the commitment of the national health care system to match the WB investments with internally generated resources for SVP operating funding. To be generated internally, resources have to be released by means of structural reforms in the health care sector.

“[Structural] rationalization and sustainability” are the key concepts that the WB will employ in its further negotiations with the government of Uzbekistan. According to Dr Jack Langenbrunner, the WB project officer for the Uzbekistan Health Loan Project, the Bank will not lend unless it sees a move towards structural rationalization and sustainability in the experimental oblasts. The new WB country director for Uzbekistan shares this view.

One of ZRP's goals is to detail policy recommendations formulated under the WB project into practical guidelines and blueprints for reforms. ZRP concurs with the WB on the importance of restructuring and will work to empower its counterparts to design and implement a plan for structural rationalization.

Among other WB priorities for the health care sector of Uzbekistan are new payment systems and provider autonomy, management information systems, and quality of services. For its part, the government of Uzbekistan wants to extend the sectoral loan agenda to ensure more attention to the issues of management information and quality.

¹ О Программе развития социальной инфраструктуры села Республики Узбекистан на период до 2000 года. Постановление Кабинета министров Республики Узбекистан от 21 мая 1996 г. № 182. Приложения 2-3 [On the Program of the Development of Rural Social Infrastructure in the Republic of Uzbekistan till the Year 2000. Executive Order #182 of May 21, 1996 by the Cabinet of Ministers of the Republic of Uzbekistan. Annexes 2-3].

2. OBJECTIVES

The TA objectives were discussed by phone with Dr Michael Borowitz, ZRP/Central Asian Republics Regional Director, and Dr Hamdia Ramic, ZRP Country Director for Uzbekistan. A tentatively defined scope of work was coordinated with the Bank's Dr Langenbrunner during a meeting on December 4, 1997. The consultant was to

- Participate in two policy planning workshops focusing on the issues of structural rationalization in the national and regional (Fergana oblast) health care sectors
- Identify the fund flow profile of the Uzbekistani health care sector by level of public spending

2.1 Objective A Policy Planning Workshops

The seminar goals were defined as follows:

- 1) To explain to the counterparts the concept of structural rationalization and scenario-building techniques,
- 2) To explain the model designed and used throughout the WB Project for simulation of restructuring scenarios and their assessment for health sector-wide cost impact,
- 3) To train the counterparts in using the model, including some hands-on exercise with scenario assessment, and
- 4) To evaluate and discuss with the counterparts data needs and changes in reporting in support of transition to a more active structural policy in the health care sector

The first seminar was intended for both the national and oblast-level health policymakers from the three pilot oblasts. Such comprehensive attendance would enable exhaustive discussions on the legal and policy issues of structural rationalization. The national regulatory bodies would get a better perspective on what needs to be adjusted in the legal and normative base to enable and encourage the restructuring. The oblasts would receive endorsement from the national regulators on some issues of restructuring and would identify insurmountable legal and political constraints. The latter then would have to be addressed through regional legislative and administrative initiatives to the extent that those initiatives can override the nationally imposed restrictions. In summary, the seminar would help determine the national/oblast mandate for structural reforms in the health care sector.

The second seminar was held in a more informal setting, as a roundtable discussion with the Fergana oblast and selected rayon health care administrators and facility managers. The purpose of this seminar was to concentrate on the micro-agenda of restructuring, i.e., to discuss practical steps and answer concerns that the main actors may have or envisage.

2 2 Objective B Fund Flow Profile

The second objective was to develop a diagrammatic view of health financing by level of budgetary system. This would require a study of annual national, oblast, and local budget reports and extensive discussions with representatives of the Ministry of Finance (MoF) and finance administrations of particular oblasts.

3 ACTIVITIES

3.1 Seminars

The planned two seminars eventually merged into a single two-day event attended by the senior staff of the Health Care Administrations of two of the three pilot oblasts Fergana and Syrdaria. The central government was represented by the State Committee for Forecasting and Statistics (*Goskomprognozstat*). The seminar was carried out as a continuous roundtable discussion comprising three distinct components: (1) a review of fund flow analysis and structural modeling done to date, (2) a detailed description of the modeling instrument, including scrolling around the programmed spreadsheet and visualization of its layout in general, and data entry and output areas in particular, (3) a scenario customization exercise. The consultant gave detailed explanations of the four key strategies of structural rationalization (see Annex 1) built into the model. He also explained which strategies are capable of producing the highest savings and what needs to be done to prevent savings potential from eroding in the process of scenario implementation. Clearly, elimination of redundant physical plant and human resources by downsizing or even closing facilities is preferable to reducing clinical activities without eliminating the resource base. In the former case, all unnecessary costs are eliminated, in the latter case savings are limited to variable costs.

Both oblasts presented their own, customized approach to structural reforms, describing restructuring strategies and setting out numeric benchmarks. The general goal was to maximally reduce the financial gap stipulated by SVP demand for recurrent funding. Whatever residual gap remains after savings potential of restructuring is exhausted, will be dealt with by any one, or a combination of the following means: downward adjustment of SVP financing needs, stretching the SVP implementation plan over a longer period of time, requesting additional resources from general revenue of the budget, and/or proposing alternative [non-public] sources of funding.

3.2 Technical Assistance

Immediately following the seminar, the consultant met with Ms Margarita Kuzmina, head of the Planning and Finance Department of the Fergana Oblast Health Administration, to discuss the system of financial allocations by level of the budgetary system. The findings from the discussion are presented in the "Findings" section of this report.

The consultant spent two days in meetings at the Ministry of Health (MoH) and the MoF. Mr Mutal Turtayev, head of the MoH Main Economic Administration and Ms Elena Bulyndenko, Chief Economist of the MoH Main Economic Administration explained the practical implications of the regulations issued by the Cabinet of Ministers and the MoH in 1997. Ms Rosa Mukhamediarova, head of the MoH Statistics Department, provided the consultant with the non-financial sections of the MoH 1996 Report for Uzbekistan and the three experimental oblasts. The material facilitates an in-depth insight into the resource base and provider network of the national and regional health care sectors. The consultant has already used it to re-estimate the impact of structural rationalization activities based on 1997 financing statistics.

Ms Lyudmila Ambartsumova, head of the MoF Health Care Financing Department, and her staff shared the information on the health sector financing by oblast, paragraph, and cost chapter for the first nine months of 1997. She also gave pre-processed output information from the national survey [*inventarization*] of health care facilities and requested the consultant to analyze the data for her. As it very soon became clear, the numbers in the table do not add up, and some of them cannot be attributed to any particular indicator. Most importantly, the national totals displayed in the table are not explanatory due to excessive aggregation. To enable a meaningful analysis, the consultant requested similar tables for each oblast, as well as textual annexes submitted by the oblasts to the MoF. Such information was promised but could not be found at once. It may be submitted to ZRP/Tashkent office in late December–early January. The requested analysis would be conducted by the consultant dependent on availability of the information. The analysis can provide important insights in the health care restructuring as occurred in Uzbekistan in 1997 under the Cabinet of Ministers Executive Order #358 of July 14, 1997 (see the *National Policy Guidelines* section of the *Findings* chapter of this report).

It took a day and a half to process the information from the MoH and the MoF and update the input components of the structural rationalization model, to re-assess the SVP financial gap, and to re-estimate the contribution of various restructuring strategies to closing the gap. A threefold update was made in the model.

- (1) Human resources of mixed facilities (most of the hospitals) were separated into inpatient and outpatient, using *Form 3 0100* from the 1996 MoH Report. Hospital financing was separated into in- and outpatient services proportionately to allocation of physicians and mid-level health personnel to inpatient departments, on the one hand, and the outpatient departments, on the other. Such breakdown is quite important in further modeling of structural rationalization, since the two components will evolve in the opposite directions according to the structural policies of the future: the model considers downsizing of the inpatient segment of the hospitals and expansion of hospital-based outpatient services.
- (2) The 1996 health financing numbers by paragraph and chapter were replaced with the data for the first nine months of 1997. Regrouping across the paragraphs was carried out, to cluster in groups facilities that will serve as distinct targets for rationalization. For example, general and specialized hospitals, both belonging in Paragraph 1, were separated into different groups since the two types of hospitals will be handled differently in the course of restructuring.
- (3) Structural rationalization plans presented by the Fergana and Syrdaria oblasts were reevaluated for their cost impact and contribution to closing the SVP financial gap. The main difference from the assessment done during the seminar derives from the new health care financing statistics. Also, several days following the seminar, the Syrdaria oblast sent a more elaborate set of scenarios and scenario-specific parameters, thus providing more inputs for scenario simulations.

The consultant met with the MoH's Ms Bulyndenko and the MoF's Ms Ambartsumova to find out the optimal timing for incorporating provider payment reform into the budget planning cycle. This was done at the request of Dr Borowitz, who seeks to introduce prospective capitation in three experimental rayons and needs to know by what date next year projected capitation rates and the accompanying explanations and justifications should be submitted to the planning agencies. The information on this issue is presented under the *Budget Planning Cycle and Provider Payment Innovation* subtitle of the *Fund Allocation by Level of Budgetary System* section of the *Findings* chapter of this report.

4. FINDINGS

4.1 SVP Financial Gap and Structural Reforms

4.1.1 National Policy Guidelines

One of the seminar's accomplishments was a conscientious agreement among the Uzbekistani counterparts that a structural change is imminent and should be planned for, regardless, even, of the World Bank loan. The attendees concurred that it would be in the best interest of the national health care sector to eliminate the most obvious redundancies in personnel and physical plant and concentrate limited funding on the viable part of the resource base. As it became clear during the seminar, the political situation has become more favorable for structural reforms lately. At least three regulatory documents contributed to the creation of a more dynamic environment in the national health policy. The contents and implications of those documents are summarized below.

Cabinet of Ministers Executive Order #358/MoH Prikaz #507

In July 1997 the Cabinet of Ministers issued Executive Order # 358² which demands more effective use of budgetary resources and, to that effect, streamlining of organizational structure of on-budget-funded organizations. The streamlining will be realized through three types of change: eliminating structural units which functionally duplicate one another, bringing facility operation in stricter compliance with their legal status, and selectively changing their ownership status. The MoH responded to Executive Order #358 with the MoH *Prikaz* #507³ setting forth the following activities aimed at increased structural efficiency in the health care sector:

- 1) "To reorganize facilities that do not meet 'modern' operational requirements" [Article 1.1]. Importantly, this provision relates to budget-funded health care facilities both inside and outside the health care sector. In particular, budget Sections 203 "The Health Care Sector" (reporting to the MoH), 202 "Research and Development," 201 "Culture," and 200 "Education" are targeted for facility reorganization. Annex 2 of *Prikaz* #507 lists the first group of health care facilities targeted for restructuring, and specifies the forms which the restructuring should take. Under Section 203 the following institutions shall change their ownership, be transferred on cost recovery, and/or will be rented out [presumably, to their own work collective, to a strategic investor, or as part of a management contract]: the

² "Об упорядочении деятельности учреждений и организаций, финансируемых за счет Госбюджета. Постановление Кабинета Министров Р-ки Узбекистан No 358 от 14 июля 1997 г. [On the Improvement in the Operation of Institutions and Organizations with On-Budget Funding]. The Executive Order #358 by the Cabinet of Ministers of the Republic of Uzbekistan, July 14, 1997]

³ "О реализации Постановления КМ РУз от 14 июля 1997 г. No 358 'Об упорядочении деятельности учреждений и организаций, финансируемых за счет Госбюджета'. Приказ Минздрава РУз No 507 от 21 октября 1997 г. ["On the Implementation of the Executive Order 'On the Improvement in the Operation of Institutions and Organizations with On-Budget Funding' of the Cabinet of Ministers of the Republic of Uzbekistan #358, July 14, 1997," the MoH *Prikaz* #507 of October 21, 1997]

Physiotherapy Dispensary [rehabilitative workout and related treatments with substantial presence of physician care], the clinic of the Semashko Rehabilitation and Physiotherapy R&D Center No 2, the Children's Osteopathy Center. The following facilities shall be merged: the clinics of the Tashkent Schools of Medicine #1 and #2, the Emergency Care Center and the National Sanitary Aviation Station, the polyclinic and the hospital of *Tashzhilinveststroy* (the Tashkent Residential Investment and Construction Corporation)

- 2) Creation of new facilities shall be authorized based on feasibility assessment of their future operation. All facilities will be processed through annual performance evaluation based on their nine-month reports [Provisions 2.1 and 2.2]
- 3) The number of personnel shall be brought in conformity with the staffing schedule, i.e., with the number of beds and workload. As was explained by Ms. Ambartsumova of the MoF, the past three years have seen a significant downsizing of bed capacity. Personnel numbers, however, have not been reduced proportionately. *Prikaz #507* seeks to restore the labor/bed norms in the inpatient facilities. According to the MoH estimations, 12,200 positions must be eliminated in the national health care sector, to do away with excessive staffing of the round-the-clock hospital beds. Some of these positions are not filled. Many other excessive personnel will be transferred from round-the-clock to day care hospital departments. Downward adjustment in labor, therefore, will not be accompanied by significant personnel layoffs. Social conflict expected to underlie systemic structural adjustment will, thus, be kept at a minimum. The MoF did not officially consider the implications of *Prikaz 507* and is somewhat skeptical about the benchmarks for personnel reduction presented by the MoH.
- 4) The Main Economic Administration of the MoH shall discontinue funding of the national-level health care facilities that fail to comply with mandated performance requirements and indicators [Provision 3.1]

Cabinet of Ministers Executive Order #532

On December 2, 1997 the Cabinet of Ministers issued Executive Order #532⁴ setting forth additional structural reforms and financial sustainability measures in the health care sector.

- 1) By January 1, 1998, the MoH will propose to the Cabinet of Ministers how to streamline the network of inpatient facilities, including rural community hospitals [*SUBs*]. Streamlining implies reorganization and elimination of small-size [*low-capacity* in official terms] facilities of listed types.
- 2) The MoH, jointly with the MoF and regional administrations, shall undertake to develop nursing homes and home-based care under the auspices of ambulatory facilities.

⁴ "О совершенствовании системы финансирования лечебно-профилактических учреждений" Постановление Кабинета Министров Республики Узбекистан № 532 от 2 декабря 1997 г. ["On Furthering the System of Financing of Health Care Facilities," Executive Order #532 by the Cabinet of Ministers of the Republic of Uzbekistan, December 2, 1997]

3) The same document rules that the goal of *utmost importance* for the MoH and regional administrations shall be the implementation of user charges along with *adequate improvement* in the quality of care and diversification of service range [Article 19] Starting on January 1, 1998 user charges shall be applied to hospital meals, except breakfast The cost of meals shall be paid by individual patients or, on their behalf, by employers, charity funds, or other sponsors [Article 1] The following population groups shall be exempt from charges for hospital meals disabled since childhood, orphans, disabled of the first and second groups (severe impairment), disabled and other WWII veterans, single pensioners eligible for welfare benefits, 'labor front' veterans of the WWII [those in employment during 1941-45], disabled during abatement of the Chernobyl disaster, servicemen in military conflicts outside their country [Annex 1] Meal charge exemption shall be extended to the following patient categories oncology, tuberculosis, psychiatric disorders and drug addiction, leprosy, consequences of exposure to radioactivity, infectious diseases, syphilis and AIDS, conditions involving intensive care, pregnancy and childbirth complicated with anemia, endocrinology

Importantly, on-budget funding saved by the introduction of paid hospital meals will be used, among other objectives, to strengthen primary services [Article 5]

4) The MoH and regional administrations shall take two months to propose change of ownership status of dental, physiotherapy, rehabilitative facilities, as well as free-standing diagnostic centers [Article 10]

Cabinet of Ministers Executive Order #453

Another government decree⁵ rules that, effective January 1, 1998, selected social service facilities owned by employers shall be transferred to municipalities [Article 1] Company-based *health care* facilities will, thus, become part of the social divestiture process To enable local governments to match additional assets with additional operating funding, a new local *tax for the development of social infrastructure* will be levied on businesses and charged to their disposable profits [Article 5] The respective tax rate shall be differentiated by territory, based on local needs The national government shall regulate the marginal rate [Article 6] No specific understanding exists at this point as to how the new tax will work The MoF is not sure if the new tax will be levied just on *ceding* employers or all businesses, and how much of the recurrent cost of divested facilities is sought to be compensated from the tax revenue

(1) Operating funding of divested company-based facilities shall be shifted from employers to the local budgets gradually and at a variable pace set forth by industry Economy-wide, the

⁵ "О переводе ведомственных объектов социальной сферы на баланс органов государственной власти на местах Постановление Кабинета Министров Республики Узбекистан № 453 от 26 сентября 1997 г ["On Transferring Employer-Based Social Services to Local Government Administrations," Executive Order #453 by the Cabinet of Ministers of the Republic of Uzbekistan, September 26, 1997]

budgets will assume 16.3 percent of operating cost in 1998, 16.5 percent in 1999-2001, and 100 percent in 2002 and thereafter [Annex 1]

Discussion of New Government Policies

To summarize the new regulations, the government seeks to embark on a comprehensive structural reform comprising three types of change

- *Service Mix* Shifting care from in- to outpatient,
- *Finance Mix* Shifting public health financing to user fees, and shifting employer-based financing to local budgets by means of earmarked tax on corporate net profits, and
- *Ownership Status* Change in the ownership status [implicitly, privatization] of selected public health care facilities, *municipalization* of company-based health care services

The common thread of mandated reforms is to increase financial sustainability in both public and non-public segments of the national health care sector. How far the government is prepared to go to deregulate the health care sector, in order to increase the motivational base for the announced changes, remains to be seen. It is likely that at least some shift will occur towards more autonomous decision making and cost recovery on the oblast and facility levels. Such change might set a somewhat more favorable stage for structural adjustment and elimination of the SVP financial gap.

The upcoming changes in the national health policy may be considered as a potential contributing force to structural rationalization plans, central to the WB Loan Project. The government, clearly, will not pave the way to deregulation or structural reforms. At best, it will become a bit more receptive to the oblast-level initiatives, and will allow negotiations over the right of the oblasts to decentralize and steer the local resource allocation and provider networks as the oblasts themselves deem optimal.

Also, the new government decrees give a new spin to the issue of SVP financial sustainability. Thus far, four strategies for closing the SVP financial gap could be considered: (1) A resource-saving structural shift within the publicly funded health care sector and allocation of savings to the SVP operating funding; (2) Stretching the SVP implementation schedule over a period of longer than four years; (3) A downward revision of SVP recurrent cost; (4) Gradual integration of employer-funded facilities into the oblast-wide structural rationalization plan. This would spread the change over a larger resource base and make it less intensive for publicly funded facilities. Alternatively, if employers become reluctant to downsize their health care network, the government could charge the industry a 'solidarity' tax earmarked for SVP operations.

Strategies (1) and (4) aim to increase the supply of resources while (2) and (3) intend to reduce the demand for resources generated by SVPs operating needs. The new government initiatives may strengthen the *supply-side* approach to closing the SVP financial gap. (i) The extension of user charges to hospital meals is tantamount to the introduction of a new source of health care funding. Importantly in the SVP context, the government encourages the territorial Health Care

Administrations to strengthen primary services by using appropriately the savings from partial transfer of meals cost to user fees (ii) Transfer of company-based clinics to municipal ownership enables the local governments to apply restructuring to a much broader resource base, thus making it less radical and more manageable. As a result, the range of tools that may be used in closing the SVP financial gap becomes more diversified. Part of the issue may be resolved by clarifying the government's new policy.

4.1.2 Fergana Oblast

The Fergana Oblast, so far, was evaluated as the most consistent proponent of structural change in the health care sector. The delegation sent to the seminar by the Fergana Health Administration was the most broadly representative and made the most significant contribution to the discussions.

Table 1 contains the restructuring plan proposed by Dr. Muminov and his team to close the SVP financial gap.

Table 1 Structural Rationalization Plan for Fergana as Proposed by the Oblast Health Administration and Evaluated on Health Financing Statistics Reported for First Nine Months of 1997

<i>Structural Rationalization Strategy and Activity</i>	<i>Reduction Rate</i>	<i>Contribution</i>
<i>I Reduction of Beds in General Hospitals</i>		<i>42.4 percent</i>
<ul style="list-style-type: none"> • Elimination of 2,500 beds by closing SUBs [rural community hospitals] • Elimination of 450 beds in <i>medsanchasts</i> [company-based clinics to be transferred under public control] 	94 percent of SUB beds 9 percent of general urban hospital beds	
<i>II Reduction of Beds in Specialized Hospitals</i>		<i>12.4 percent</i>
<ul style="list-style-type: none"> • Elimination of 150 beds for sexually transmitted diseases • Elimination of 100 beds in the dispensary for drug and substance addicts • Elimination of psychiatric beds 	50 percent, or 6% reduction of specialized beds 100 percent 20 percent	
<i>III Closure of Rural Ambulatory Facilities</i>		<i>28.3 percent</i>
<ul style="list-style-type: none"> • Elimination of 92 SVAs • Closure of 300 FAPs 		
<i>TOTAL SVP Financial Gap – Closed</i>		<i>83.1 percent</i>
<i>TOTAL SVP Financial Gap – Remains</i>		<i>16.9 percent</i>

4.1.3 Syrdaria Oblast

The structural rationalization plan for Syrdaria was presented by the oblast health administrator during the seminar. A week after, a courier was sent to Tashkent with a revised outline of restructuring. The later version specifies some of the activities proposed in the initial draft. Some other activities, however, are neither confirmed nor cancelled. The following table summarizes both versions of the oblast health care restructuring plan.

Table 2 Structural Rationalization Plan for Syrdaria as Proposed and Adjusted by the Oblast Health Administration and Evaluated on Health Financing Statistics Reported for First 9 Months of 1997

<i>Structural Rationalization Strategy and Activity</i>	<i>Reduction Rate</i>	<i>Proposed during the seminar (+) and confirmed the week after (++)</i>	<i>Contribution</i>
I Reduction of Bed Capacity in General Hospitals <ul style="list-style-type: none"> • Elimination of 220 beds in general hospitals other than Central Rayon Hospitals and SUBs • Elimination of beds in Central Rayon Hospitals • Elimination of 130 out of 200 beds in SUBs [rural community hospitals] 	14 % 14% 66 %	+ ++ ++	14 5%
II Reduction of Publicly Funded Bed Capacity in Specialized Hospitals <ul style="list-style-type: none"> • Privatization of Physiotherapy Hospital in Yangtyer (105 beds) and Maternity and Children's Physiotherapy Hospitals (60 beds) • Closure of 20 beds for drug and substance addicts • Closure of TB Hospital in Bayaut rayon (30 beds) and TB dispensary in Syrdaria rayon (80 beds) • Elimination of 100 out of 200 psychiatric beds 	48 8 % 50 % 41 % 50 %	 ++ + ++ +	11 3%
Closure and Transformation of Rural Ambulatory Facilities <ul style="list-style-type: none"> • Closure of 125 FAPs and transformation of 32 FAPs into SVP local offices • Closure of 68 SVAs 	100 %	 ++ ++	10 9%
IV Elimination of 30 Ambulance Posts (workload to be shifted to SVPs)	50 %	++	7 7%
V Elimination of Blood Bank and Transfusion Service	100 %	+	1 1%
VI Threefold reduction in unit gas and water consumption by equipping facilities with meters in each department We have played this pledge down to a more realistic 10%	20%	++	9 1%
VII Of 50 SVPs to be restructured out of SVAs, 34 will be subsidized at 15 % by employers (collective farms) who previously funded local SVAs		++	6 7%
VIII Admission rate reduction general hospitals by 7%, specialized hospitals by 6% central rayon hospitals by 7% SUBs by 5%		++	1 1%
IX ALOS reduction general hospitals by 8%, specialized hospitals by 12%, central rayon hospitals by 11% SUBs by 10%		++	1 5%
TOTAL SVP Financial Gap – Closed			63 9 %
TOTAL SVP Financial Gap – Remains			36 1 %

4 1 4 Navoi Oblast

Since Navoi Oblast was not represented at the seminar, the originally proposed rationalization plan is pending validation by the counterparts Table 3 displays such a plan in its updated version, based on the health financing numbers reported for the first 9 months of 1997

Table 3 Benchmarks for Structural Rationalization as Proposed by the Abt TA Team for Navoi, Reconciled with Health Financing Statistics Reported for First Nine Months of 1997, and Pending Validation by the Counterparts

<i>Structural Rationalization Strategy and Activity</i>	<i>Reduction Rate</i>	<i>Contribution</i>
<i>I Reduction of Beds in General Hospitals</i>		<i>63 4 percent</i>
• Urban general hospitals	18 3%	
• Rayon hospitals	20 0%	
• SUBs	50 0%	
<i>II Reduction of Beds in Specialized Hospitals</i>		<i>9 6 percent</i>
• Short-stay specialized hospitals	50%	
• Dispensary for drug-addicts	100 %	
• TB dispensaries	50 %	
• Psychiatric hospitals	50%	
<i>III Closure of Rural Ambulatory Facilities</i>		<i>27 0 percent</i>
• Elimination of 22 SVAs		
• Closure of 83 FAPs		
<i>TOTAL SVP Financial Gap –Closed</i>		<i>100 percent</i>
<i>TOTAL SVP Financial Gap –Remains</i>		<i>0 percent</i>

4 1 5 Preliminary Evaluation of the Proposed Plans

Most of the scenarios proposed by Syrdaria oblast will need better quantification The tentatively assessed aggregate savings potential (63 9 %) may turn out to be significantly lower if reduction of bed capacity (sections I and II of the above displayed outline) is not accompanied by across-the-board cost savings Discussions held during the seminar suggest lack of commitment to facility closure among the Syrdaria health sector leaders They perceive downsizing and other forms of capacity reduction in terms of personnel layoffs but not in terms of taking the physical plant out of operation

The situation is more favorable in Fergana oblast health administrators there seem to understand the difference between full cost versus variable cost savings and are determined to effectively close as many facilities as may be dictated by considerations of cost-efficiency

4 2 Fund Allocation by Level of Budgetary System the Case of Fergana Oblast

4 2 1 Central Budget

The central (*republic* in former Soviet terms) budget is only minimally involved in health financing in Fergana oblast. It funds only the physiotherapy (healing water treatments) hospital-sanitarium located in Chimeon. Central funding was discontinued in 1996 for Shemikhardan sanitarium and in 1997 for three nursing schools. All listed facilities were transferred from the central to the local budgets.

Similarly to Fergana oblast, the central budget divested itself of expenditure on sanitarium and nursing schools nationwide. The central budget remains in charge of the centrally located teaching hospitals and specialized clinics representing the national state of the art in their specialties. Fixed investment (buildings, structures, capital equipment, fixtures, and related producer durable assets except furniture) continues to be funded from the central budget as well. Central allocations cover the entire cost of SVP construction, including the cost of SVP remodeling from the existing facilities. Out of UZS 31 million obligated for the SVP construction program, UZS 20 million has already been spent.

4 2 2 Local Budgets

The local budgets are comprised of the oblast- and rayon/city-level budgets. Altogether, they provide recurrent funding under all paragraphs of budget outlay classification, each paragraph representing a type of health care provider or activity in the health care sector. The only exception to this statement is the network of rehabilitative sanitarium, which used to be financed jointly from the local budgets, labor unions, and *kashlak* (village) budgets. Until 1992-93 the feldsher-midwife posts (FAPs) also were funded from the *kashlak* budgets. At present, most FAPs are financed from rayon budgets. A few, including the FAPs located close to the cities of Kokand and Kuvasai, are financed from city budgets.

By level of local funding, there are 35 oblast, four city, and 19 rayon health care facilities in Fergana oblast (not to mention SUBs, SVAs, and FAPs which are considered as part of the central rayon hospitals).

4 2 3 Fund Allocation Process

Funds are allocated from the MoF to the Oblast Finance Administration. The Oblast Health Administration plans and allocates resources for all health care facilities—oblast-, city-, or rayon-level. Funds are allocated by chapter-specific norms of financing and depend on historic resource base and utilization of care. Cities and rayons do not have the right to move funding across the chapters.

The planning and allocation is a two-way process. It starts with the application for resources presented by facilities to rayon/city finance departments. Once rayon/city financial plans are

aggregated from facility-level projections, they are submitted to the Oblast Health Administration and incorporated into the oblast-wide health care financing plan. The latter will be scrutinized by the Oblast Finance Administration. If it consents to the benchmarks and justifications worked out by the Oblast Health Administration, both parties will cosign executive order on health care resource allocation for the next fiscal year.

Reallocation of funds among rayons/cities in the course of the fiscal year is possible on an *ad hoc* basis provided that local governors (*khoakims*) sign a respective ordinance. Consent of the ceding rayon/city is necessary.

4.2.4 Fund Disbursement Process

The Oblast Finance Administration transfers funds on the bank account of the Oblast Health Administration to finance the oblast-level health care facilities. The funds for the city-level facilities flow from the Oblast Finance Administration to the city finance departments which, in turn, pay them to providers. The funds for rayon-level facilities flow from the Oblast Finance Administration to central rayon hospitals which then allocate them to SUBs, SVAs and FAPs by bed capacity and population served.

4.2.5 Budget Planning Cycle and Provider Payment Innovation

Due to constant under-collection of tax revenue, the budgets have to be balanced by means of outlay sequestration. Needless to say, the budget appropriation targets are continuously challenged, if not ignored, when it comes to cash disbursement. A persistent discrepancy between obligated and allocated amounts has affected the budget planning algorithm. Starting in 1996, the MoF skips the bottom-up stage of the planning cycle, whereby application for funds for the next fiscal year would be presented to the MoF by the sectoral ministries as the product of upward aggregation of applications from the users of budget funds. “Why bother collecting applications from the users if we know we will not be able to meet them due to under-collection of revenue?”—Such is the explicit logic that motivated the MoF to truncate the budget planning cycle. The MoH continues to submit its funding projections to the MoF, covering only part of the health budget administered at the national level. The Oblast Finance Administrations are left completely out of the process.

Given the new “simplified” procedure, the annual fiscal planning cycle starts off at the MoH in the second half of August. In September, MoF develops health budget projections for the MoH and by oblast. In October, the draft budget is compiled out of sectoral projections. In November parliamentary deliberations begin. The budget is adopted by the parliament at the end of December.

A prospective capitation package, therefore, needs to be finalized by mid-August to submit it to the MoH (primarily, for their professional approval), and by September to submit it to the MoF, for inclusion in the budget planning process.

5. CONCLUSIONS AND RECOMMENDATIONS

The year of 1997 brought about important changes in the official attitudes towards structural rationalization. The government announced a turnaround in the economic growth trends according to *Gozkomproгноzstat*, the country has entered the stage of *macroeconomic recovery*. Even if such a statement is correct, tax and export revenues of the budget are, and are expected to remain constricted in the years to come. The government is realistic about it and, therefore, considers two options for balancing the budget: (1) Plan outlays generously and sequester appropriated funds in the course of the fiscal year in line with the revenue gap; (2) In anticipation of the [imminent] shortfall of revenues, take longer-term measures to improve financial sustainability of the publicly funded sectors. The executive orders of the Cabinet of Ministers and supplementing *Priказы* of the MoH reviewed in the *Findings* chapter of this report seem to favor the latter approach by proposing certain steps towards broader institutional liberalization and concrete legal and administrative reforms in the health care sector.

The 1997 regulatory package legitimizes (1) ownership reforms based on privatization, social divestiture, and property lease, (2) system-wide restructuring by shifting services to outpatient settings, and (3) facility rationalization by means of merger, internal reorganization, and personnel cuts.

A distinctive approach to the above changes is top-down administration rather than empowerment of the stakeholders. The government selects enterprises that shall divest their social service facilities, and it schedules the transfer of ownership and recurrent funding to the local governments. To eliminate redundant costs, the government resorts to micromanagement of labor resources: the personnel/bed ratios will be reestablished as indicative norms, approximating the 1990 staffing levels. The MoH determines health care institutions subject to rationalization and what forms the rationalization should take. A *dirigistic* approach is instrumental in eliminating the first and most visible layer of structural and operational inefficiencies and should be applauded as a long-awaited departure from previously stagnant policy. Self-regulatory mechanisms of restructuring, based on regulated competition, provider incentives, and equitable interactions among all the stakeholders, should come into play early on to take structural change further from its initial stage and make it sustainable.

Based on a promise of change in the government policy, Health Care Administrations of the experimental oblasts have become much more prone to the concepts and tools of structural rationalization than they were at the beginning of 1997. Both Fergana and Syrdaria oblasts demonstrated good understanding of the cause-effect links that translate facility-level structural rationalization into system-wide cost savings. Most importantly, the concrete plans they proposed at the seminar and are continuing to refine and develop, are coordinated between Health and Finance Administrations, and general oblast government. The fact that such coordination has become possible, demonstrates the emergence of at least some political base behind structural rationalization plans and, therefore, better prospects for successful implementation of those plans.

At the same time, it would be misleading to overestimate the observed changes. The central fiscal system is still dominated by institutional fear of ceding control over funding and funding mechanisms to local governments and providers of services. Health sector administrators, audacious as they may be in their plans of structural rationalization, would lack practical knowledge of how to manage restructuring. Physicians and patients, for their part, feel suspicious and alienated, knowing all too well how little value would be assigned to their interests under any kind of bureaucratically-driven reforms.

The initial promise of change is yet to be developed into an effective policy action and sustainable implementation. The technical assistance should aim to consolidate grounds under structural change by addressing the following issues:

- 1) *To assist the experimental oblasts with building and evaluating a more comprehensive list of structural reforms*, consistent with the SVP program targets and time frame, and mindful of existing political constraints. The consultant proposes to conduct two-day focus group sessions in each oblast, involving health administrators and key clinical staff. Such sessions will be held in extension of the previous policy design workshops, and will be more participatory for the counterparts. The exercise will pursue the following objectives: (1) To find out if a more systematic use could be made of the restructuring strategies originally proposed by the TA team to close the SVP financing gap. The Fergana and Syrdaria oblasts elaborated on some strategies, adapting them to local conditions, yet left out others. We should ask the local counterparts if they believe that the remaining strategies are viable and should be included in the restructuring plan. Had they been excluded on purpose, *ZdravReform* would come to a better understanding why they are believed to be inapplicable. (2) To the counterparts' credit, they have proposed elimination and merger of facilities and services some of which were not covered by the initial set of restructuring guidelines. The focus groups should be encouraged to identify more such strategies with the eventual purpose to "turn every stone" in exploring the potential for pro-efficiency structural rationalization.
- 2) *To advise health care administrators and facility managers on restructuring management*. The consultant recommends developing a case-based "master plan" of facility rationalization with modifications for urban hospital, polyclinic, and rural health care network anchored in central rayon hospital. Such a plan should be presented in a how-to manual and detailed into a step-by-step blueprint. A decision-making tree will institute a significant part of the algorithm, relating strategies and techniques of restructuring to a facility clinical and resource utilization profile, local health care market structure, and local socio-economic and political environment. A facility-level *rationalization plan* will be supplemented with the oblast-level component. The latter will detail functions and activities that should be carried out by the local fiscal, labor, and health care authorities. The local government will have to learn how to help providers of services undergoing structural rationalization to optimize the use of their physical plant by selling, renting, or shifting excessive space to alternative sources of revenue, how to plan ahead for personnel layoffs, how to liquidate assets, shift clinical load to alternative delivery settings, and deal with other issues that make part of the restructuring agenda. The roles of the local government would be those of coordination,

authorization, legal rehabilitation (justification of the facilities' new rights, competencies, and responsibilities), selective subsidization of the restructuring effort, public relations

- 3) *Assist with downward revision of the SVP operating budgets* To close the SVP financing gap in full, structural change will have to exceed the levels and intensity dictated by rationalization of the health care network. To prevent restructuring from becoming “irrationally” radical, the counterparts and the WB alike will have to consent to a “residual” financing gap to be filled by methods other than rationalization. One such method is a downward re-estimation of the SVP recurrent cost. General considerations of proportionality suggest that costs associated with physical plant maintenance and replacement should be significantly reduced. In currently used assessments, these costs stand out as the principal category of recurrent spending. The Abt technical assistance team has built fixed asset maintenance and replacement cost in the budget under the “Depreciation” heading, while the WB experts presented it as a “10% maintenance cost.” Both approaches are alien to the Uzbekistani budget planning rules and procedures, as conversations at the MoF showed. Depreciation, however, seems to be more self-explanatory and, therefore, easier to advocate and estimate. It can be built up, based on variable useful life by category of fixed assets (buildings, structures, durable equipment, minor equipment) and by kind of equipment. The easiest way to reduce the amount of depreciation is to take out the *building-related component of depreciation*. Since SVPs are not considered as autonomous legal and economic entities, they would not be expected to rebuild their physical plant 20 to 30 years from now. After all, why should they bear respective cost as long as other publicly owned health care facilities do not bear it? *Depreciation of equipment* could be re-estimated downward by extending useful life of some basic furniture, fixtures and pieces of equipment, which are resistant to moral obsolescence and, therefore, can stay in operation as long as they remain functional. These are considerations of Dr Borowitz, ZdravReform/Central Asia Regional Director. They may be quantified into new SVP operating budgets once the Bank makes a final decision as to how much of the SVP financing gap may be addressed outside the structural rationalization plan.
- 4) *Identifying the list of issues that require reconciliatory adjustment in or exemption from the legislation. Proposing appropriate amendments* The oblast health care administrators made it clear that they would remain hesitant about embarking on structural reforms unless the national government assures them that such reforms are legal, and the oblast health care systems and medical facilities will be allowed to reap the fruit of rationalization by keeping the resulting savings. Also there was a persistent request to the government to disburse funds to the health care sector in a timely manner and at the appropriated amounts. The Fergana oblast, also, demanded a better hedging from inflation, complaining that existing annual deflation allows for no more than 15-17 percent of annual cost escalation in the health care sector. Among other issues that require regulatory clearance are (a) non-itemized fund-allocation, (b) performance-based methods of reimbursement, (c) a higher degree of provider autonomy, e.g., as regards acquisition and disposal of assets, outsourcing of medical and ancillary services, entering into direct contractual relationships with payors and referral providers, (d) simplified rules and procedures of human resource management, including issues such as duration of the workweek, flexible work schedules, hiring/firing, staffing

schedule, (e) preferential tax treatment of revenues from user charges and other non-public sources, (f) simplified market entry rules, e.g., diversification of the menu of legal statuses that health care facilities may choose from, in order to accommodate their professional and business needs, waiver of registration fees for physician practices, fast-track market valuation of fixed assets in the context of facility privatization or lease. All listed and similar issues may be resolved by making appropriate amendments in pertinent bylaws, or by proposing a presidential decree that would legalize the experiment and key experimental mechanisms, thus, taking precedence over the existing regulations. The latter “block” approach may be preferred to the former “itemized” approach, since it spares the effort of identifying and dealing with multiple pieces of regulations that would require revisions.

- 5) *To assist with preparation of a health financing reform* that has been maturing in Uzbekistan for the past two years and is expected to start in 1998 with system design and legislative work. The new health financing mix, according to the perception popular throughout the NIS, should be built around a mandatory health insurance (MHI) program to be funded from earmarked payroll tax and on-budget contributions. The *ZdravReform* Program may have a rare opportunity to influence the legislative process in Uzbekistan right from the inception point. This would prevent the local reformers from mistakes made in Russia and Kazakstan when designing and implementing the MHI system. In particular, the ZRP should encourage its counterparts to (1) focus the legislative effort on drafting and promoting a Health Financing Reform Law rather than a Mandatory Health Insurance Law, thus, advocating a more diverse range of funding sources than just MHI, (2) balance the reform agenda by paying equal amount of attention to resource generation and resource allocation mechanisms, as well as to institutional change that would consolidate the ground under both components, (3) balance sustainability and equity agendas of health care reforms by proposing, on the one hand, broader inclusion of households in health care financing and, on the other hand, income-related subsidies for the needy, (4) link health financing reforms to fiscal and other economic reforms. Technical assistance should begin with a five-day interactive policy workshop. Its goal will be to present a comprehensive menu of options and criteria of choosing among them. This would create a stronger base for informed policy choice, than out of purely domestic resources. An important part of the seminar will be a system design exercise, during which the students will be asked to compile optimal reform packages out of the basic options available to health care reformers worldwide. Concrete preferences will derive from different sets of assumptions relating to reform values, economic and political realities. These options will be explained in general terms and illustrated from various country experiences in a *background concept paper* to be prepared and distributed prior to the seminar. To secure high attendance and undivided attention of the audience to the learning process, the seminar should be moved outside Tashkent, so that key government executives could feel disentangled from their daily responsibilities. Following the seminar, a feasibility study will be conducted to quantify a health financing mix developed during the seminar and recognized by the national policymakers as potentially optimal combination of sources and mechanisms of health financing. Following the feasibility study, a White Paper of Health Financing Reform in Uzbekistan will be drafted and submitted for approval to the Cabinet of Ministers. The Health Financing Reform Law will be drafted based on the approved version of the White Paper. The listed

four stages should be carried out in a six to nine-month period during 1998. A small task force staffed with ZRP and local experts will coordinate the process and ensure key technical inputs.

- 6) *To assist with institutional reforms in the health care sector*. As was mentioned in the *Findings* section of this report, The Cabinet of Minister's Decree #532 endorses privatization of dental, physiotherapy, rehabilitative, and stand-alone services. Such turnaround in the government policy that so far did not favor *destatization* in the social service sectors (throughout the NIS, not just in Uzbekistan), may create a vast front of technical assistance work along the lines that so far could not be pursued due to lack of political acceptance of ownership reform. An initial offer of help may include development of not-for-profit legal status and drafting a pertinent national law, market valuation of facility assets (for property redemption or just accounting purposes), preparation of a package of legal documents for facility incorporation, design of a master business plan and guidelines for its customization to various clinical and business needs and conditions, market research to estimate market potential for designated types of care, training of counterparts in operations and financial management of health facilities, development of policy and contractual guidelines for purchasing authorities to incorporate non-public health care facilities into a unified competitive market of medical services.
- 7) *To assist key health policy and financing agencies in their current reform work*. ZRP seeks to provide strategic guidance to health care reforms in Uzbekistan. To be successful in this endeavor, the project should continue to build professional trust among its consultants and key executive and technical staff of the Uzbekistani government agencies. One way to do this is to selectively engage in the current work of the MoF, MoH, and *Goskomprognozstat*. On several occasions such help was requested and accepted before. New assignments, worthwhile to consider, may include help to the *Goskomprognozstat* with preparing 20-year Long-Range Forecast and 10-year Mid-Term Outlook for the health care sector (which it is requested to submit to the Cabinet of Ministers in five-year cycles), help to the MoF with analyzing the outcomes of the national health facility survey [*inventarization*] conducted in 1997, help to the *Goskomprognozstat* with revising the program of household budget survey to improve reporting on user health care spending, help to the MoH on methodological and statistical development of prospective capitation.
- 8) *To strengthen domestic expertise in health care financing and administration*. ZRP may want to look for laconic yet effective ways of informing the professional community of Uzbekistan of the needs of the national health care sector and reforms. A series of guest lectures might be planned at the National Management Academy and the National School of Public Administration. More focused and regular discussions should be held with the faculty of economics and business administration departments of these and other reputable educational institutions. The multidisciplinary approach should be emphasized, and the roles of experts in non-clinical occupations explained. A small group of the brightest economists, lawyers, and government administrators working in teaching and research positions in the Academia should become involved in ZRP-sponsored training and TA activities.

6 REFERENCES

6.1 Activity Log

December 9 Discussions with Dr Hamdija Ramic ZRP/Uzbekistan Country Director regarding the seminar agenda and current priorities of the TA process in Uzbekistan

December 10 Edited the 'Fund-Flow Analysis A review of Methodology' in English and translated it into Russian Held discussions with Dr Michael Borowitz on the seminar agenda and sequence of events

December 11-12 Conducted the seminar jointly with H Ramic and M Borowitz

December 13 Wrote up the findings from the seminar discussions

December 15 Held discussions with M Borowitz, H Ramic, and S Whickham regarding methodology and techniques of capitation rate setting for primary care facilities in the experimental rayons Scheduled appointments at the MoH and MoF

December 16 More discussions with the ZRP technical team joined by P Hauslohner, Abt/WB project director, and Julian Simidjyski, the ZRP consultant on the legal aspects of provider payment reforms in the Central Asian countries The main issue was the legal waiver for the experimental health care systems

December 17-18 Three meetings at the Ministry of Health and two meetings at the Ministry of Finance As a result, all the information necessary for updating structural rationalization plans according to the first nine months of 1997 statistics was collected

December 19-20 The fund-flow model for each oblast was rerun based on the new statistical information The Syrdaria restructuring plan was adjusted based on the newest proposals delivered to Tashkent by a courier from the Oblast Health Administration The output from the newest trial was written up and presented to P Hauslohner Parts of his final report to the World Bank were reviewed at his request

6.2 List of Key Contacts

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7 ANNEXES

ANNEX 1 FUND-FLOW ANALYSIS A REVIEW OF METHODOLOGY

General Characteristics

Fund Flow Analysis (FFA) is a tool of economic analysis commonly used to evaluate systems of financing. A system of financing consists of three components: (1) generation of resources for and their allocation to the system, (2) allocation of resources within the system, (3) institutional environment.

FFA addresses all the three components by studying: (i) Sources of financing and how funds are mobilized from each source, (ii) Recipients (users) of funds within the system, objectives of spending, and methods of payment utilized to allocate funds to the users, (iii) Regulatory and administrative institutions who operate the system, and political, economic, and legal context in which the system functions.

FFA-based studies may have various purposes, such as evaluation of the system's current status, projection of its evolution in the course of reforms, assessment of impact expected from particular scenarios of institutional and structural change.

The FFA relies on a basic input-output model that tracks funds by their origin and use. In the health care sector, a twofold break-down of health care expenditure is quite essential. A. By payor, e.g. public budgets, social health insurance, private insurance, employer-based direct provision, user charges. B. By health service/activity type, e.g. inpatient care, ambulatory services, public health programs, health care administration. In practice, most applications of the FFA method, also, require that the health care spending is decomposed by type of facility, kind of cost and cost category (fixed, variable, semi-variable).

The FFA method allows to examine some relevant issues deriving from and relating to health policy and reform agendas, e.g. (1) whether the health financing system is balanced on the revenue and expenditure sides, (2) whether key economic institutions contribute to health financing commensurately with their capacity, (3) whether resources are allocated within the health care sector effectively (as dictated by health care needs) and efficiently (in a cost-minimising way), (4) how additional funding expected from a newly-mandated source (mechanism) of financing may be best allocated to provision of care, (5) how existing funds can be re-routed to accommodate additional need for services, creation of a new type of provider institution, reduction (elimination) of one of the existing types.

The structure of an FFA model may vary dependent on the goals and objectives of FFA-based study, availability of information, and level of detail permissible under existing resource and time constraints. Key to meaningful application of the FFA method is an agreement among policy and payor institutions alike that the health care sector should be steered towards more competitive

environment, with higher roles reserved for financial incentives, provider autonomy, and facilitation of market entry and exit

Application to the SVP Project

In the context of the current project FFA method was utilized to identify and evaluate several scenarios of structural change in the health care sectors of three experimental oblasts. The common thread of all the scenarios was to find out how savings in the health care budget may be achieved and used for closing the SVP gap. To close the SVP gap means find money within the health care sector for operating funding of newly created SVPs. The basic question to answer was whether the system, actually, can produce sufficient savings to ensure operating funding for the planned number of SVPs.

In close collaboration with the local consultants we have identified main structural imbalances and areas of redundancy in the oblast health care sectors, i.e., (1) excessive beds in the inpatient sector in general and specialized and long-term care institutions, in particular, (2) excessive utilization of inpatient services in terms of high hospital admission rates and increased length of stay, (3) excessive number of rural outpatient and mixed facilities, such as SVAs and FAPs, given that SVPs are coming to take over their functions.

Based on listed inefficiencies the following four strategies of structural rationalization were proposed: A Reduction of hospital bed capacity; B Reduction of hospitalization rate for the remaining beds; C Reduction of average length of stay on the remaining hospital beds; D Closing of SVAs and FAPs.

These strategies were transformed into initial set of reduction rates, and an agreement was achieved at what pace to shift those rates upward if the initially achieved savings turn out to be insufficient to close the SVP gap. It was also assumed that facility closures (strategies A and D) result in the elimination of all costs, while reduction in utilization (strategies B and C) saves variable costs only.

As the next step, the oblast health care budgets were broken down by 23 uses of funds (types of facilities/public health programs) and 11 cost categories. Then costs under each category were separated into fixed, variable and semi-variable costs. For example, food and drugs were classified into variable costs. Wages and salaries were split between fixed costs (80 percent) and variable costs (20 percent). This decision was based on the counterpart's view of how difficult or easy it will be to reduce health personnel if volume of services declines. The 80/20 split is based on the assumption that on each five percent reduction in clinical volume, no more than 1 percent reduction in personnel may be expected. Further at this stage, total, fixed, and variable costs by type of medical facility were estimated. This allowed to calculate the amount of savings possible under projected rates of reduction in provider capacity and utilization of services.

However, this was not enough to achieve the final goal of our study, i.e. estimate the amount of funding that structural rationalization can produce, specifically, for SVPs. The reality of structural

reform is that only part of the savings from rationalization and elimination of inefficient facilities will become available for allocation to SVPs. To identify this part we had to estimate the other part, which will have to be reallocated along the lines predetermined by restructuring itself. For example, as a consequence of closing long-term dispensaries, patient flow will increase to short-stay hospitals and outpatient care institutions. Hence, part of the savings must be obligated to facilities facing increased workload due to changed referral patterns.

This general idea was developed into a set of assumptions as to which types of facilities will assume more work and how originally generated savings should be allocated to balance additional workload with additional funding. For example, it was estimated that 50 percent of patients averted from hospitalization by downsizing (closing) short-stay hospitals and reducing length of stay, will receive treatment in outpatient departments of the same hospitals (e.g. outpatient surgeries), while the other 50 percent will be treated in stand alone city polyclinics. From specialized hospitals inpatient care will be shifted in equal shares of 25 percent to short-stay general hospitals, same specialty hospitals (to match with additional resources the increased case mix complexity of the remaining practice), city polyclinics, and outpatient dispensaries. From SUBs patients will be reallocated to rayon hospitals (40 percent) and SVPs (60 percent). Once 'substitution effects' were projected relative to the patient flow they had to be translated into shifts in fund flows. With this purpose in mind we had to estimate such substitution ratios as resource intensity of one patient day in a short-stay hospital relative to one patient day in a long-term inpatient care facility, as well, as one hospital case to one outpatient case.

The latter, probably, was the most challenging problem. Intensive discussions with local clinicians and Dr. Michael Borowitz led to the following assessments: to treat a hospital case in an outpatient setting it will take, on average, 33 percent of wages and salaries, 30 percent of housekeeping expenses, 150 percent of pharmaceutical expenses, and a proportionate amount of other costs. The latter means, that miscellaneous cost categories are estimated by their share in baseline total costs. The above cost-itemized estimations resulted in the following integral ratios of outpatient-to-inpatient care costs (varying by oblast): cases formerly treated in urban general hospitals will be treated at 26 percent to 48 percent of hospital cost once transferred to outpatient, in specialized hospitals at 34 percent to 50 percent, in rayon hospitals at 38 percent to 44 percent, in rural community hospitals at 37 percent to 44 percent.

As the next step, we calculated the amount of funds needed by 'substituting facilities'. Since they are going to provide care at more economical cost than facilities from which care is shifted, part of the savings will become available for allocations to 'elective' uses, in our case, to SVPs. This elective part was calculated in value terms and compared with the amount of SVP financial gap. In all oblast the gap was not closed by the initially set reduction rates. Hence, the fund flow model performed a number of iterations until the savings reaching SVPs got to match the gap.

In the final run it was calculated that in Syrdaria Oblast 43.7 percent of the oblast health care expenditures will have to be stirred up by restructuring, of which 70.7 percent (or 30.8 percent of the oblast health care expenditure) will reach SVPs to fill the SVP financial gap. In Navoi Oblast corresponding numbers are 18.1 percent, 69.7 percent, and 12.6 percent. In Fergana Oblast, respectively, 16.2 percent, 10.7 percent, and 65.8 percent.

These numbers allowed to conclude that in Syrdaria Oblast the four-year targets for structural change are unrealistically high. Restructuring will have to be deep beyond the needs for rationalization and, at any rate, impossible to manage. It is highly improbable, therefore, that the system will be able to generate resources sufficient for operating funding of the planned number of SVPs. By contrast, in Navoi and Fergana Oblasts the required intensity of structural change is commensurate with the size of the health care sector and is justified by efficiency considerations. Hence, the SVP gap may be filled with internally generated funds. The SVP program is likely to be sustainable in those two oblasts, provided that the oblast administrations will disburse funds allocated to the health care sector, will commit themselves to and carry out the outlined structural change.

**ANNEX 2 Parameters of SVP Financing Gap and Structural Adjustment
November 1997**

Table 3 1 Annual Operating Costs of Rural Physician Posts, Baseline Year Prices

Type of Facility	US\$	Uzbek Som
SVP 1	28,478	1,893,234
SVP 2	37,723	2,509,196
SVP 3	46,497	3,116,913

Table 3 2 The SVP "Financing Gap" SVPs' Projected Operating Costs as a Percentage of Total Projected Government Expenditures on Health Facilities (in Uzbek Som, 1997 as the Base Line)

Oblast	Four-Year Health Expenditure	Four-Year SVP Operating Budget	SVPs as Percent of Health Budget
Fergana	8,140,000 0	869,649 8	10 7%
Navoi	2,645,200 0	334,619 4	12 7%
Syrdaria	2,483,600 0	756,096 8	30 4%

Table 3 3 Projected Savings from Closures of SVAs and FAPs, Uzbek Som 1,000

		Fergana	Navoi	Syrdaria
1997-2001 Health Budget		8 140 0	2 645 2	2 483 6
SVP Operating Budget, a 4-year period		869 6	334 6	756 1
a SVA Budget		0 368	0 173	0 498
a FAP Budget		0 217	0 114	0 439
Savings From SVA and FAP Closing If	Planned SVAs Closed	90 8	5 6	82 2
	Planned FAPs Closed	51 3	34 5	132 7
	All SVAs Closed	140 6	20 2	150 7
	All FAPs Closed	342 8	74 4	172 2
Eliminated Financial Gap in Percent of Total Financial Gap If	Planned SVAs and FAPs Closed	16 3%	12 0%	28 4%
	All SVAs and FAPs Closed	55 6%	28 3%	42 7%
Remaining Financing Gap in Percent of Health Budget	Planned SVAs and FAPs Closed	8 9%	11 1%	21 8%
	All SVAs and FAPs Closed	4 7%	9 1%	17 4%

Table 3 4 The SVP "Financing Gap" SVPs' Projected Operating Costs as a Percentage of Total Projected Government Expenditures on Health Facilities (in Uzbek Som, 1997 as the Base Line)

Oblast	Four-Year Health Expenditure	Four-Year SVP Operating Budget	SVPs as Percent of Health Budget
Fergana	10,093,600 0	869,649 8	8 6%
Navoi	4,046,800 0	334,619 4	8 3%
Syrdaria	2,640,400 0	756,096 8	28 6%

Table 3 5 Components of Prospective Rationalization Plans in the Three Leader Oblasts and their Effect on the Financial Gap by the Year 2000

	Urban General Hospitals (including Medsanchast)	Urban General Hospitals (excluding Medsanchast)	Specialty Hospitals	Rayon Hospitals	SUBs	SVAs (units)	FAPs (units)
Fergana (to close SVP financing gap at 100%)							
Elimination of Facilities and/or Hospital Beds	12%	15%	40%	25%	70%	66	62
Admission Rate Reduction	4%	5%	0%	5%	0%		
ALOS Reduction	12%	15%	15%	15%	10%		
Navoi (to close SVP financing gap at 100%)							
Elimination of Facilities and/or Hospital Beds	11%	22%	55%	30%	80%	22	83
Admission Rate Reduction	3%	5%	0%	5%	0%		
ALOS Reduction	13%	15%	15%	15%	10%		
Syrdaria (to close SVP financing gap at 100%)							
Elimination of Facilities and/or Hospital Beds	50%	55%	70%	75%	70%	46	80
Admission Rate Reduction	23%	25%	25%	25%	20%		
ALOS Reduction	27%	30%	30%	30%	25%		

**Table 3 7 Contribution of Structural Reforms to Aggregate Savings
Based on the Rationalization Plan Presented in Table 3 5**

Type of Structural Change	Fergana	Navoi	Syrdaria
Reduced bed capacity in long-term care institutions	15 5%	5 9%	5 3%
Reduced bed capacity in short-stay hospitals	63 8%	72 1%	73 0%
Reduced admissions on the remaining beds	2 3%	3 4%	6 5%
Reduced ALOS on the remaining beds	9 1%	11 4%	7 9%
Closed FAPs and SVAs	9 2%	7 3%	7 3%
Total structural change	100 0%	100 0%	100 0%

Table 3 6 Selected Marginal Effects of Structural Change in the Health Care System of Fergana Oblast (in Uzbek Som 1,000)

Parameters	Total	Savings, Reallocated to				Savings	Savings
	Savings generated	City General Hospitals	City Polyclinics	Rayon Hospitals	SVPs	Oblast Health Expenditure	Allocated to SVPs, as % of Financing Gap
In Uzbek Som 1,000							
<u>A dispensary for sexually transmitted diseases</u>							
Facility closed	41,673	4,357	8,704		28,612		
Admission reduced by 1,000 cases	3,656	447	894		2,325		
A SUB closed	3,387		447	923	2,016		
A SVA closed	368				368		
A FAP closed	68				68		
In Percent							
<u>A dispensary for sexually transmitted diseases</u>							
Facility closed	100%	10 5%	20 9%		68 7%	2 05%	19 17%
Admission reduced by 1,000 cases	100%	12 2%	24 4%		63 4%	0 18%	1 68%
A SUB closed	100%		13 2%	27 3%	59 5%	0 17%	1 56%
A SVA closed	100%				100%	0 018%	0 17%
A FAP closed	100%				100%	0 003%	0 03%

**Table 3 8 Potential Savings from Different Kinds of Structural Change in Syrdarya Oblast
(In Millions of Uzbek Som)**

Subject to Elimination (Reduction) are	Annual Savings from Reduction	Contribution of Savings to SVP Financing in a 4- Year Perspective, If Eliminated (Reduced) by the End of			
		Year 1	Year 2	Year 3	Year 4
10 beds in general hospitals	164 1	656 4	492 3	328 2	164 1
10 beds in specialty hospitals	383 0	1532 0	1149 0	766 0	383 0
10 beds in rayon hospitals	462 6	1850 4	1387 8	925 2	462 6
10 beds in SUBs	633 3	2533 2	1899 9	1266 6	633 3
100 admissions in general hospitals	941 4	3765 6	2824 2	1882 8	941 4
100 admissions in specialty hospitals	624 9	2499 6	1874 7	1249 8	624 9
100 admissions in rayon hospitals	734 9	2939 6	2204 7	1469 8	734 9
100 admissions in SUBS	849 4	3397 6	2548 2	1698 8	849 4
1000 patient-days in general hospitals	699 4	2797 6	2098 2	1398 8	699 4
1000 patient-days in specialty hospitals	698 8	2795 2	2096 4	1397 6	698 8
1000 patient-days in rayon hospitals	731 1	2924 4	2193 3	1462 2	731 1
1000 patient-days in SUBs	672 0	2688 0	2016 0	1344 0	672 0

ANNEX 3 АНАЛИЗ РЕСУРСНЫХ ПОТОКОВ ОБЗОР МЕТОДОЛОГИИ

Общая характеристика метода

Анализ ресурсных потоков (АРП) – это метод экономического анализа, используемый обычно для оценки систем финансирования. Любая система финансирования состоит из трех подсистем: 1) механизм формирования ресурсов и их поступления в систему, 2) механизм использования ресурсов внутри системы, 3) институциональная среда.

АРП охватывает все три подсистемы, занимаясь следующими вопросами: а) источники финансирования и методы мобилизации ресурсов из каждого источника, б) получатели ресурсов внутри системы, цели ресурсопотребления, методы финансирования с помощью которых ресурсы выделяются потребителям, в) регулирующие и административные учреждения, которые управляют системой, политический, экономический и правовой контекст, в котором эти учреждения осуществляют свои функции.

АРП может быть подчинен различным целям, таким, например, как оценка сложившегося положения дел в финансовой системе, прогноз изменений в системе в ходе предстоящих реформ, оценка влияния на систему конкретных сценариев институциональных и структурных преобразований.

В основе АРП лежит традиционная модель “затраты - выпуск”, с помощью которой удается проследить движение финансовых средств по источникам их происхождения и направлениям использования. В здравоохранении важную роль играет детализация финансовых потоков по двум критериям: во-первых, по держателям средств (источникам финансирования), как то: государственный бюджет, социальное страхование здоровья, частное страхование здоровья, средства населения, во-вторых, по типам медицинской помощи и видам деятельности в здравоохранении, например, стационарная помощь, амбулаторно-поликлинические услуги, программы охраны общественного здоровья, административно-управленческая деятельность в здравоохранении. В большинстве случаев АРП также требует разбиения расходов на здравоохранение по типам ЛПУ, а также видам и категориям затрат (постоянным, переменным и условно-переменным).

АРП позволяет исследовать ряд важных вопросов, вытекающих из повестки дня реформы здравоохранения как раздела государственной политики и отрасли народного хозяйства. В их числе: 1) Сбалансированы ли финансовые поступления и расходы в системе здравоохранения? 2) Насколько вклад каждого экономического института в финансирование здравоохранения соответствует финансовым возможностям этого института? 3) Отвечает ли распределение ресурсов внутри здравоохранения требованиям целевой и затратной эффективности? 4) Каков оптимальный вариант использования средств из вновь открывшегося источника финансирования? 5) Как можно перераспределить средства из имеющихся источников финансирования, чтобы обеспечить ресурсами дополнительную

потребность в медицинской помощи, новый тип ЛПУ, сокращение или ликвидацию одного из традиционных типов медицинских учреждений?

Структура и алгоритм АРП видоизменяются в зависимости от целей и задач анализа, наличия информации и уровня детализации, допустимого при имеющихся ресурсах финансирования исследования и времени, отпущенного на его проведение. Осмысленное применение АРП возможно лишь при согласии между регулирующим центром и финансирующей стороной о необходимости создания более конкурентной среды в здравоохранении за счет повышения роли финансовых стимулов, расширения оперативно-хозяйственной самостоятельности ЛПУ, создания условий для беспрепятственного выхода на регулируемый рынок медицинской помощи и ухода с него.

Анализ ресурсных потоков в контексте Программы развертывания СВП

В контексте настоящего проекта метод АРП применялся для разработки и оценки нескольких сценариев структурной перестройки здравоохранения трех экспериментальных областей. Все сценарии подчинены единой задаче изыскать возможности для экономии средств в действующей лечебно-профилактической сети в объеме, достаточном для удовлетворения потребности в текущем финансировании вновь создаваемых СВП. Исходный вопрос, на который предстояло ответить, сводился к следующему: В состоянии ли вообще система сэкономить средства для обеспечения текущего финансирования запланированного числа СВП?

В сотрудничестве с местными консультантами были выявлены следующие структурные дисбалансы и зоны неэффективности в здравоохранении: 1) избыточная мощность коечных фондов стационаров вообще и стационаров специализированной и долговременной помощи, в частности, 2) завышенные объемы оказания стационарной помощи (в показателях уровня госпитализации населения и средней продолжительности госпитализации), 3) необоснованно высокое число сельских амбулаторных и смешанных учреждений, в частности, СВА и ФАПов, если учесть, что СВП должны взять на себя основную часть их функциональной нагрузки и, тем самым, заменить их.

С учетом вышеназванных факторов неэффективности были предложены четыре стратегических подхода к структурной рационализации: I Сокращение коечного фонда стационаров II Снижение уровня госпитализации на сохраняющемся коечном фонде III Уменьшение средней продолжительности госпитализации на сохраняющемся коечном фонде IV Закрытие СВА и ФАПов.

Перечисленные стратегии были развернуты в количественные параметры. Каждый параметр задает процент сокращения показателя, лежащего в основе той или иной стратегии. На этом этапе были выработаны договоренности о шаге приращения параметров в случае, если первоначально заданные значения не выводят на требуемую сумму экономии. Требуемая сумма экономии равна годовому объему текущего финансирования СВП. Было также условлено, что закрытие ЛПУ (стратегии I и IV) обеспечивают экономию по полному кругу затрат, в то время как

сокращение объемов помощи без закрытия ЛПУ (стратегии II и III) позволяет сэкономить только на переменных затратах

На следующем шаге алгоритма бюджет здравоохранения каждой экспериментальной области был разбит на 23 направления использования (типы ЛПУ и виды деятельности в здравоохранении) и 11 видов затрат. Затем каждый вид затрат был отнесен к категории постоянных, переменных или условно переменных затрат. Например, питание и медикаменты были отнесены к переменным затратам. Заработная плата на 80% была отнесена к постоянным затратам, на 20% -- к переменным затратам. Такая пропорция основана на представлениях узбекистанских коллег о возможностях высвобождения медицинского персонала по мере сокращения объема лечебной работы. Пропорция 80/20 основана на предположении о том, что на каждые 5% сокращения объема лечебной работы численность занятых будет снижена лишь на 1%. Следующим шагом была оценена стоимость постоянных, переменных и условно переменных затрат по каждому типу ЛПУ. Полученные данные выводят на расчет экономии по каждой стратегии структурной перестройки.

Тем не менее, рассмотренной выше информации не достаточно для ответа на конечный вопрос нашего исследования, а именно: Какой объем средств может быть сэкономлен для текущего финансирования СВП? Реальность структурной перестройки такова, что лишь *часть* экономии от ликвидации неэффективных ЛПУ и сокращения объемов помощи достигнет СВП. Чтобы оценить размер этой части, нам предстояло измерить размер другой части фонда экономии – той, которую понадобится перераспределить в направлениях, задаваемых самой структурной перестройкой. Например, последствием закрытия диспансеров долговременной помощи станет увеличение нагрузки на стационары кратковременного содержания и амбулаторные учреждения. Следовательно, часть экономии от закрытия диспансеров должна быть потрачена на увеличение финансирования ЛПУ, нагрузка на которые возрастет в результате перераспределения потока пациентов.

Представленная выше общая идея получила развитие в количественных допущениях относительно того, какие конкретно типы ЛПУ должны будут принять на себя дополнительную нагрузку и как потребуется перераспределить часть высвобожденных средств для того, чтобы сбалансировать дополнительный объем лечебной работы дополнительным финансированием. Например, согласно нашим оценкам, 50% пациентов, отведенных от госпитализации в результате сокращения размеров или закрытия больниц острой помощи и сокращения сроков пребывания на койке, будут обслужены в поликлинических отделениях тех же больниц (скажем, по линии амбулаторной хирургии), а другие 50% получают помощь в самостоятельных городских поликлиниках. Пациенты, отводимые от госпитализации на койки специализированных больниц, будут направлены равными частями по 25% в больницы общего профиля, те же специализированные стационары (на практике речь идет о компенсации дополнительным финансированием повышения клинической сложности лечебной работы в результате отсева относительно простых случаев), городские поликлиники и амбулаторные диспансеры. Пациенты закрываемых СУБов будут перераспределены на 40% в районные больницы и на 60% в СВП.

После того, как “эффекты замещения” одних ЛПУ другими были установлены с точки зрения перераспределения потока пациентов, эти же эффекты надо было представить с точки зрения перераспределения потоков финансирования. Для этого потребовалось оценить такие соотношения как ресурсоемкость одного пациенто-дня в больнице для острых случаев к ресурсоемкости одного пациенто-дня в больнице долговременного содержания, а также затраты на одного стационарного больного к затратам на одного амбулаторного больного.

Последнее оказалось довольно трудной задачей. Интенсивные обсуждения с местными клиницистами и д-ром Боровицем привели к следующим заключениям: чтобы вылечить амбулаторно один случай, отведенный от госпитализации, потребуется затратить в процентах к больничным затратам 33% по статье “Заработная плата”, 30% по статье “Хозяйственные расходы”, 150% по статье “Затраты на медикаменты” и пропорциональные затраты по другим статьям. *Пропорциональные* в данном контексте означает, что объем затрат по прочим затратам будет установлен с таким расчетом, чтобы их доля в суммарных затратах оказалась той же, что и в исходном бюджете данного типа ЛПУ. При заданных выше постатейных соотношениях суммарные коэффициенты замещения характеризуются следующими показателями: случаи, традиционно лечившиеся в многопрофильных стационарах, в амбулаторных условиях будут обслуживаться с затратами по различным областям от 26% до 48% от затрат стационара. Аналогичный показатель для случаев, отводимых от госпитализации в специализированные больницы, составит от 34% до 50%, в районные больницы – от 38% до 44%, в СУБы -- от 37% до 44%.

Основываясь на вышеприведенных оценках, мы рассчитали общий объем средств для финансирования дополнительной лечебной работы в ЛПУ, нагрузка на которые в условиях реструктуризации возрастает. Этот объем меньше, чем высвобождаемые средства, поскольку лечебная работа перемещается в более экономичные условия.

СВП получают разницу между средствами, высвобождаемыми в результате структурной перестройки, и средствами, которые требуются для финансирования дополнительной лечебной работы в действующих учреждениях. Получив искомую разницу, мы сравнили ее с прогнозной потребностью СВП в текущем финансировании. Ни в одной из трех областей первоначально установленные сокращения не обеспечили закрытия ожидаемого от СВП финансового дефицита. Потребовалось несколько итераций, прежде чем расчетная экономия сравнялась с расчетным дефицитом.

В конечном счете было установлено, что в Сырдарьинской области 43,7% годового бюджета должно быть перераспределено в процессе структурной перестройки. В этом случае 30,8% бюджета будут доступны для текущего финансирования СВП. Таким образом, СВП получают 70,7% средств, перераспределяемых в процессе реструктуризации. В Навоийской области соответствующие показатели составят 18,1%, 12,6% и 69,7%, в Ферганской области – 16,2%, 10,7% и 65,8%.

Приведенные показатели позволяют заключить, что в Сырдарьинской области задачи четырехлетней структурной перестройки непомерно высоки. Структурная

перестройка в интересах СВП должна будет принять более широкие масштабы, чем это требуется интересами рационализации действующей лечебно-профилактической сети. Интенсивность структурной перестройки окажется выше, чем позволяют возможности управления ею. Следовательно, представляется маловероятным, что система сумеет выделить из себя ресурсы, достаточные для текущего финансирования запланированного числа СВП. В отличие от Сыр-Дарьи, в Навоийской и Ферганской областях требуемые масштаб и интенсивность структурной перестройки соразмерны возможностям и интересам рационализации здравоохранения. Связанный с СВП финансовый дефицит может быть закрыт за счет внутренних ресурсов текущего финансирования. Программа внедрения СВП в этих двух областях может быть признана финансово обоснованной при трех условиях. Областные администрации будут отпускать средства запланированные на финансирование здравоохранения, выскажут приверженность структурной перестройке и осуществят ее в рекомендованных масштабах.