



ZdravReform
ЗдравРеформ

TRIP REPORT NO. CAR/KAZ-19

**ORGANIZATIONAL DEVELOPMENT OF THE BOARD
OF THE MHIF AND PILOT HOSPITALS
IN THE SOUTH KAZAKSTAN
INTENSIVE DEMONSTRATION SITE**

**Shymkent, Kazakstan
July 26–August 8, 1995**

Prepared by under Task Order No. 231:
George Purvis III

Submitted by the ZdravReform Program to:
AID\ENI\HR\HP

AID Contract No. CCN-0004-C-00-4023-00
Managed by Abt Associates Inc.
with offices in: Bethesda, Maryland, U.S.A.
Moscow, Russia; Almaty, Kazakhstan; Kiev, Ukraine

EXECUTIVE SUMMARY

The development and implementation of an effective National Mandatory Health Insurance Fund (NMHIF) in Kazakhstan is of critical importance to the future success of the Oblast level Mandatory Health Insurance Funds (OMHIF) and to the successful implementation of health services throughout the country. Coincidentally, with the National Health Insurance Fund, is the successful development of the South Kazakhstan Intensive Demonstration Site (SKO-IDS) and the planned Health Maintenance Organization (HMO) at the Phosphorus Hospital in Shymkent. The major purpose of this trip was to work with both the NMHIF in Almaty and the HMO in Shymkent, on Organizational Development (OD) activities, to evaluate program initiatives, and to assist with the effective development of management systems and organizational structures which will ensure the future success of both of these groups.

The work with the NMHIF was the significant portion of the visit and centered around the development and presentation of papers on mission, vision, goals, programs as well as management and organizational structure and the resultant functions, responsibilities, authorities, and possible programs and activities of the Fund. This process was initiated and resulted in securing the trust and confidence of the new Director General and assuring him that the *ZdravReform* Program could provide him with significant Technical Assistance (TA) which he will require in the development and implementation of the Fund over the next few years. Major policy papers in the areas of MHIF payment systems, information systems, rationalization, restructuring, and quality assurance, as well as board and management issues were presented and were well received.

The second part of the trip was working with the Shymkent HMO, and was focused upon reviewing information and plans on the development and implementation of the HMO by April 1, 1996. This required detailed review of workplans, assistance with the prioritization of activities, and the development of assignments to complete the work on time. Additional work was done on developing further recommendations on the board of directors, organization, and management structure of the HMO. This resulted in reviewing and laying out exactly what could and could not be implemented by April 1, 1996. While there is much to be accomplished, the Program personnel and the counter parts believe that this can be accomplished within the time frame. This report outlines the various steps and deliverables which must be completed and prioritizes them according to what needs to be done before April 1, 1996, and what items can wait until after the starting date.

BACKGROUND

This trip was a follow-up to a prior visit in August 1995, when a Board/Management Workshop was conducted for the proposed new board of the SKO-MHIF, and a Strategic Planning Workshop for the management of three hospitals (Phosphorus, Emergency, and City Hospital #2) in Shymkent were conducted. Considerable effort has gone into the preplanning of the Health Maintenance Organization in Shymkent, and this trip was meant to follow-up on previous work and to outline priorities and immediate plans to get the HMO operational by the first of April, 1996.

The work with the National Mandatory Health Insurance Fund (NMHIF) came less from extensive planning and more as an opportunity, due to recent relationships of Michael Borowitz in Almaty and the recent formulation of a management team developing the new NMHI Fund, and was not part of the consultant's original scope of work (SOW). Due to some changes in planning and recently proposed possible budget reallocations, it was decided to delay the work in Shymkent on the Family Group Practices. It was decided that it would be more cost effective to finalize the development of the Family Practice payment systems in the Karakol IDS and then to transfer that experience and expertise to the Shymkent IDS at a later date. Consequently, these items in the original SOW were delayed until some future date. The original SOW is outlined in the Annex A of this report:

OBJECTIVES

The objectives for this trip are outlined in the consultant's SOW (see Annex A) and are outlined below as follows:

1. To work with the new management team of the National Mandatory Health Insurance Fund (NMHIF) in Almaty to assist with the development of mission, vision, goals, programs, management, organizational structures and systems;
2. To assist the NMHIF to outline the Technical Assistance (TA) required from them by the *ZdravReform* Program to ensure the effective development and implementation of the Fund;
3. To work with the new Phosphorus Hospital HMO management team, and the IDS advisors, consultants and counterparts, to develop a realistic and workable plan for the implementation of the new HMO by April 1, 1996;
4. To develop a board of directors for the hospital-based HMO and assist with management systems development and quality assurance.

FINDINGS AND RECOMMENDATIONS

NATIONAL MANDATORY HEALTH INSURANCE FUND: VISION, GOALS AND PROGRAMS

This paper outlines the proposed vision, goals, and programs of the National Mandatory Health Insurance Fund (NMHIF), as discussed by the Director General of the Fund and as envisioned by the *ZdravReform* Program. Furthermore, the paper outlines the technical assistance programs which may be implemented over the next three years.

The *ZdravReform* Program, managed by Abt Associates Inc., is willing to provide Technical Assistance (TA) to the National Mandatory Health Insurance Fund in the following areas:

- Developing Provider Payment Systems

- Information Systems to Support Payment Methods
- Rationalization and Restructuring of Facilities and Services
- Quality Assurance and Quality Control Processes

This Technical Assistance will be in the form of training of a core group of Oblast and National Mandatory Health Insurance Fund personnel in all of the areas listed above, technical expertise in calculation of rates for provider payment systems, technical expertise and advice in the areas of computers and information systems, technical knowledge and advice in the areas of developing and implementing programs for quality and cost improvements, and rationalization and restructuring methods for improving efficiencies of the health care delivery system.

I. VISION

The National Mandatory Health Insurance Fund (NMHIF) will operate as a “Corporate Holding Company” providing management and financial “oversight, monitoring, approval and policy guidelines” to the Oblast Funds. The National Fund will provide leadership in developing economic incentives for improving the quality and cost effectiveness of health care services, will develop pricing guidelines to ensure adequate diagnosis and treatment of diseases, will develop structural changes in payment systems to ensure long term financial health for providers, will develop risk adjusted pricing of benefit packages, and will improve the overall efficiency of the health care delivery system.

II. GOALS

The National Mandatory Health Insurance Fund will have the following goals during the first three years of its operation:

1. To develop an evolutionary process of change in funding of health care services from the present system to a more progressive system with economic incentives and market mechanisms;
2. To develop a pricing structure which is both effective and efficient, and is practical and easily understood by all parties involved;
3. To develop an organizational and management structure which will allow sufficient autonomy to the Oblast Funds while still retaining a strong corporate oversight, monitoring , policy guidelines and approval function;
4. To implement changes in pricing which will bring about a rationalization of facilities and services, improvements in quality of services, and development of more cost effective and efficient methods of diagnosis and treatment of diseases.

III. PROGRAMS

The programs listed below are outlined in a “concise” format, and are supported by the various “attachments” which provide a more in depth discussion of the subject. Further discussion of each technical assistance area will be needed to develop the specific assistance and resources which may be required.

A. HOSPITAL/HEALTH SERVICES PAYMENT SYSTEMS

In order to provide a smooth transition from the present system to a more progressive system over a three year period, and to give all parties time to learn new methods, the following payment system options are proposed:

Hospital Payment

Market oriented hospital payment systems typically provide a payment for the production of a defined unit of hospital output. Some payment systems are per diem systems providing a payment for each day spent in the hospital. Other systems are per case systems providing a payment for each discharge from the hospital. Both per diem systems and per case systems are intended to provide payment equal to the average cost of producing a unit of output in an efficient hospital.

The incentives to increase hospital length-of-stay (LOS) found in a per diem payment system are quite strong—the longer the hospital stay, the higher the reimbursement. In the long term, we do not recommend a per diem hospital payment system in Kazakhstan. However, a per diem system can be used as an intermediate step toward a case-based system. It is fairly simple to implement, can be constructed using available data, and facilitates the collection of data required to construct a case-based system.

The hospital payment system must be closely coordinated with phase one of the rationalization and restructuring plan. This is important because closing hospitals will help align the competitive system and create savings which can be reinvested into the hospital payment system. Real savings come from closing hospitals, not just reducing beds because of the high level of fixed costs, such as utilities, in the system.

First Year

The implementation of a per diem hospital payment system consisting of approximately 5–10 different per diem categories based largely on medical specialty. The per diem system contains two components which are multiplied together to obtain the hospital payment amount. One is a relative weight for each per diem category, scaled around 1.0 in order to differentiate the level of cost for each per diem category. The second is a base rate which is the average cost of a bed day and can be adjusted to different funding levels. Annex B explains hospital payment further and demonstrates the cost accounting system required to construct the per diem categories.

The relative weights could be either national or oblast based. National weights have the advantages of encouraging a national health care model, reducing problems due to incomplete data from some oblasts, and helping to ensure simultaneous implementation of new payment methods in all oblasts (identified as important by the Director of the National MHIF). In addition, it would help to define

an appropriate policy role for the National MHIF, with operational aspects handled by the Oblast MHIF's.

The base rate would be determined for each oblast depending on the level of funding available. The National MHIF could have a policy and operational role in reallocating some budget and employer revenue across oblasts in order to equalize the base rate, resulting in more equitable resource allocation.

The purpose of this plan is to provide input to the programs of the National MHIF, not to outline an operational workplan. However, the steps required to construct the per diem hospital payment system are contained in Annex B. To implement this system, the National MHIF needs to collect the required data. After the data is collected, the *ZdravReform* Program could provide technical assistance to construct the hospital payment system in about two months.

Second–Third Year

The implementation of a case-based hospital payment system using diagnosis to classify patients into different payment categories. The data needed to construct this system will be collected through the hospital bills submitted under the per diem system. The *ZdravReform* Program has developed a case-based hospital payment system for implementation in Kyrgyzstan.

Payment for Outpatient Services

The implementation of new outpatient payment methods is more difficult and time-consuming than hospital payment because most of the payment options involve restructuring of the health system. Restructuring in the primary care sector is required to implement any form of capitated rate payment (a fixed fee to provide a defined set of services). A capitated rate would be paid to provide a comprehensive set of primary care services to an individual, however; the polyclinics are currently organized to provide relatively specialized care. Individual, family or general practitioners, small family group practices consisting of a therapist, pediatrician, and obstetrician/gynecologist, or polyclinics reorganized to provide all primary care services are required to reimburse providers using a capitated rate.

There are four other factors which need to be considered in determining the form of the outpatient payment system. First, the financial incentives should be different for primary care vs. outpatient specialty care. The incentives should encourage primary care and discourage or be neutral toward outpatient specialty care. Second, the payment system needs to consider the different structure of the health care delivery system in rural vs. urban areas. Third, the role of polyclinics vs. hospital outpatient departments needs to be evaluated. Finally, the role and objectives of cost recovery or user fees in the system needs to be considered.

The options listed below vary across the parameters of level of delivery system restructuring required, incentives desired for primary vs. specialty outpatient care, and different delivery systems in urban vs. rural areas. They need to be evaluated together with the rationalization and restructuring section of the plan before decisions are made on the form of outpatient payment. It is

important to note that the payment system ultimately could be a combination of some of the options listed below, for example, a mixed model consisting of a partial capitated rate and a fee schedule.

Primary Care

In general, it is recommended that FGP's be maintained and adequate funding provided either on a salary or fee-for-service basis (payment according to charges they submit). These primary care providers located in remote parts of the community are a good element of the current health care delivery system.

Rural Areas—all options are available in both the short term and longer term for rural areas because SVA's basically function as family practices, providing all primary care services. This means they could be reimbursed using a capitated rate in the short term.

1. Capitated rate for SVA's—SVA's enroll patients and are paid a capitated rate for each enrolled individual.
2. Primary care practitioners are paid a set fee per visit based on a fee schedule.
3. Primary care practitioners continue to be reimbursed on a salary basis, but SVA's become entities independent from the central rayon hospital.

Urban Areas

1. Short-term

- a. Primary care practitioners are paid a set fee per visit based on a fee schedule.
- b. Primary care practitioners continue to be reimbursed on a salary basis.

2. Longer term—allowing time for delivery system restructuring.

- a. Primary care practitioners at adult, children's, and women's polyclinics are merged and the new polyclinic paid a capitated rate.
- b. Small family group practices consisting of a therapist, pediatrician, and obstetrician/gynecologist are formed and paid a capitated rate.
- c. Primary care practitioners are paid a set fee per visit based on a fee schedule.
- d. Primary care practitioners continue to be reimbursed on a salary basis.

Specialty Care and Diagnostic Tests

1. Short-term

- a. Outpatient specialists and diagnostic tests are paid a set fee per unit of service reflecting the relative value of the production inputs contained in the unit of service.

2. Longer term

- a. Multispecialty diagnostic centers are formed and become part of the capitated rate payment system.
- b. Outpatient specialists and diagnostic tests are paid a set fee per unit of service reflecting the relative value of the production inputs contained in the unit of service.

B. INFORMATION/COMPUTER SYSTEMS TO SUPPORT PAYMENT METHODS

The need for information and computer systems to support the payment methods outlined above are critical to the success of the newly implemented systems.

National and Oblast MHIF Systems

The National and Oblast MHI Funds require the institutional capacity to pool funds and manage new provider payment systems. The development and installation of new computer systems is especially important. Provider payment on a treated case basis increases the base unit for reimbursement many times. For example, the base unit for hospital payment could increase a thousand times from budgets for hundreds of facilities to per diem or case-based payment for hundreds of thousands of treated hospital cases. This very large increase in the number of transactions requires the development of automated systems to manage the payment process.

Computer systems would be able to handle construction of rates for the payment systems, recording of clinical information from facility bills, payment of providers for services, operation of a quality assurance system, analysis of health statistics, and enrollment of the population. Attachment A contains a description and flowchart of the computer systems currently being developed by *ZdravReform*.

An accounting system would record all financial transactions from defined source payment documents, interact with the banking system and provide financial reports for the MHIF. Internal auditing and control procedures need to be developed. The organizational structure and staff positions of the National and Oblast MHIF's must be designed to allow management of the payment methods and computer systems. Finally, the relationships between the MHIF and the treasury and banking system need to be clearly defined. The transition to a stable market economy may require the banking system to gradually shift its focus toward handling financial transactions efficiently, away from serving as a control mechanism.

Facility Systems

Cost accounting systems are needed to provide facility managers with financial information to make sound decisions about the type and mix of services produced by the facility. Clinical information systems would allow analysis of services provided to patients and be used to create the hospital bill facilities to submit to the MHIF. Both cost accounting and clinical information is required by the MHIF to determine payment rates for providers.

Financial accounting systems are important to allow efficient management of financial transactions and produce financial reports. Current accounting systems provide a good starting point; however, they could benefit from the introduction of accrual accounting and more sophisticated financial reporting to present available information in a more useful form.

C. RATIONALIZATION AND RESTRUCTURING OF THE HEALTH SYSTEM

As previously highlighted in a number of papers, the health care delivery system of Kazakstan, as with other countries of the former Soviet Union, has an *over* supply of health facilities and *excess* personnel. Rationalization of facilities is necessary in order to generate the necessary savings in hospitals in order to have some funds to shift to primary care. This section will outline a two phase methodology to assist the Oblast level MHI Funds to “rationalize and restructure” the existing health care delivery system.

In order to take advantage of the new payment systems and the resulting market competition that will develop among health facilities, the Oblast level Funds will need assistance in the process of rationalization and restructuring. The present delivery system was designed around a very logical system of Feldsher Units, SVA’s, SUB’s, Rayon, Municipal, and Oblast level institutions. “Rationalization” is a process of reviewing all levels of existing health facilities, services, equipment, and personnel, and determining which of these facilities might be consolidated, closed, reduced, or improved. The rationalization process would assist in reducing the number of facilities and personnel, and would reduce the over supply of these resources, thus providing greater incentives for efficiency and higher payment rates among the remaining institutions. Recent study has shown that there is a serious excess of SUB’s and Municipal Hospitals in many areas. Rationalization of these existing facilities would be Phase I of the process, and would result in immediate savings in utilities, food, personnel, and medications in each Oblast. The real savings will only come from *closing* facilities, as only reducing beds produces little or no real savings. This initial rationalization will improve the structure of the health delivery system to prepare for the introduction of competition and the savings can be reinvested in more equitable payment rates for providers. This rationalization process would be done during the first year of the new MHIF implementation. (See rationalization methodology in Attachment “C-1”).

“Restructuring” is the process of bringing about change in the type of facilities, the type of personnel required, and the methods of diagnosis and treatment, which will result from the changes in the payment system (changing from payment for beddays and outpatient visits to a case-based or capitation based systems). The present health care delivery system has a critical shortage of primary care physicians and an excess of specialists, subspecialists, and superspecialists providing care out of large polyclinic facilities. The present system is built on a large number of specialty institutions (Maternal, Pediatrics, Adult, Oncology, Tuberculosis,

Sexually Transmitted Disease/Dermatology, and Psychiatry), which depend on a high number of referrals to/from these polyclinics and hospitals. This system has resulted in large quantities of unnecessary referrals, ancillary tests, hospitalizations, and long stays in the hospital. Phase II of the process would be restructuring the present system toward more cost effective primary medical care and away from more expensive polyclinic and hospital care. This process would begin in the second year of the implementation and take longer to complete (2–4 years), but will result from the changes in the payment system and will bring about major efficiencies and cost savings within the total health care delivery system. (See Attachment “C-2”).

In conjunction with the restructuring and rationalization process is the need to develop more autonomy on the part of all of the health care providers (hospitals, polyclinics, SVA’s, and individual physician practitioners). Some providers would become independent of the Ministry of Health and would be able to focus more on their own future activities. Increased autonomy will allow individual physicians to form into group practice arrangements, both primary care and specialized care, and will provide more competition within the system. Working together over a number of years, the restructuring process will reduce the cost of services, improve the quality of and satisfaction with the services provided, and will result in a more cost effective system of delivering primary, secondary, and tertiary level medical care to the population.

D. QUALITY ASSURANCE AND QUALITY CONTROL PROCESSES

In order to ensure that health services are delivered to the population in an effective manner, it is necessary to develop quality assurance and quality control processes, procedures, and practices. The specifics of these processes are presently being developed and include the following:

Admission and Discharge Criteria

High volume procedures in hospitals will need to have admission and discharge criteria established for each procedure to ensure that patients are not admitted unnecessarily and that they are not kept in the hospital longer than necessary, as well as ensuring they are not discharged prematurely.

Model Practice Protocols

The high volume/high cost procedures will require practice protocols to ensure that all patients are being treated in a high quality and cost effective manner. Primary care physicians will also need practice protocols to assist in the diagnosis and treatment of patients at the primary level, and to ensure that patients receive appropriate care which is also high quality and cost effective.

Referral Guidelines

Primary care practitioners will need to have guidelines developed for referrals to specialists, subspecialists, and superspecialists, in order to ensure that patient are not referred unnecessarily to specialists.

Drug Formulary

Hospitals and outpatient facilities will need to develop drug formularies and improved drug information systems to ensure cost effective prescribing, procurement and distribution of efficacious pharmaceuticals and medications. The MHIF would only pay for medications and pharmaceuticals that are included in this list. This is presently underway in a number of the Oblast demonstration areas.

Licensing Criteria and Standards

A system of licensing of facilities will need to be established, which has a number of criteria and standards for compliance with accepted norms of quality, equipment, personnel, and behavior. Any licensed facility will be able to receive the standard MHIF payment rates.

NATIONAL MANDATORY HEALTH INSURANCE FUND ISSUES, PROBLEMS, AND RECOMMENDATIONS

Outlined below is one of the key papers submitted to the management of the Fund for consideration and discussion. The purpose of the paper was both educational and thought provoking, hopefully to allow them to solicit more assistance from the *ZdravReform* Program.

Background

This paper is designed to briefly outline some of the *issues, problems, and recommendations* in the establishment and management of the National Mandatory Health Insurance Fund from the perspective of the needs of the health insurance and delivery system in Kazakhstan. These areas have been identified from the experience of the *ZdravReform* Program, World Bank, and others working in the South Kazakhstan Oblast, Dzheskasgan, Issyk Kul Oblast in Kyrgyzstan, and other NIS countries.

Existing Health System Problems

The experience of the World Bank and *ZdravReform* have identified a number of problems in the existing health delivery system:

1. The medical delivery system is dominated by hospitals, with approximately 70 percent of the funding going to hospitals, and only 30 percent going to more cost effective primary care activities.
2. The hospitals, polyclinics, SUB's, SVA's, are funded for their services based on the historical method of beddays, and outpatient visits instead of quality and outcome indicators.
3. The referral rates to specialists, number of beds per population, admission rates and the length of stay in hospitals are 3 to 5 times the acceptable rate of other countries.
4. The number of physicians per bed, nurses per bed, total employees per bed are 2 to 3 times the acceptable ratios of other countries.
5. The existing system of numerous specialty hospitals (TB, STD, Psychiatry, Oncology), and the various existing treatment protocols are not only inefficient but also not efficacious.

Existing Health System Opportunities

The experience of the *ZdravReform* Program and the World Bank in a number of the NIS countries has identified a number of *opportunities and possibilities* to reform the existing system, which would result in a more effective and efficient use of the limited resources, resulting in improved levels of health status of the population at a lower cost:

1. New insurance payment systems, based on capitation and other managed care concepts can reduce unnecessary referrals, hospital admissions and reduce the length of stay in hospitals.
2. Refocusing of resources from hospital care to primary care can greatly reduce the overall cost of medical care and significantly improve the health status of the population, as well as improving the satisfaction with health care services.
3. Training and education of primary care physician practitioners can significantly reduce referral rates, admission rates, length of stay, and improve quality and outcome indicators.
4. A process of “rationalization” of medical facilities can significantly reduce the number of facilities and the number of beds as well as reducing the overall cost of operation.
5. The *National Mandatory Health Insurance Fund* can effect significant change in the medical care system through focusing their efforts towards reform of the system through utilization of experience, experiments, demonstrations, tools, payment systems and other knowledge developed by various World Bank, *ZdravReform*, and local community experience.

Recommendations for National Mandatory Health Insurance Fund

Based on the experience of other NIS countries, and specifically on the *ZdravReform* Program and World Bank projects, the following recommendations are submitted for consideration in the development of the National Mandatory Health Insurance Fund of Kazakstan:

1. The National Fund should operated primarily as a corporate “Bank Holding Company”, providing “oversight, monitoring, and policy” guidelines to the Oblast funds. Oversight, monitoring, and policy are usually defined as “approval and decision making” functions on the budget and financial plan, business plan, financial performance, cash flow, key appointments, major project authorization, national regulation and legal issues, audit (financial and clinical), quality of care, evaluation of executive performance, and policy formulation and development on key national issues on health insurance. (See Attachment A)
2. The National MHI Fund should focus primarily on cash flow considerations, “sources and uses” of funds, audit activities, and other centralized oversight, monitoring, and policy formulation and development issues.
3. The “day to day” operations and management of pricing, collection, payment and delivery of services should be left to the local Oblast MHI Funds, with oversight and monitoring by the National Fund.
4. A central role of the National MHI Fund should be to provide leadership in the restructuring of the medical delivery system utilizing the experiences and successes of the various local Oblast funds, the lessons learned from various demonstration projects, local and international

experience and advice, and payment and quality assurance methods, tools and techniques proved to be successful elsewhere.

5. A central function of the National Fund should be providing leadership in improving the quality of services and reducing the cost of services, through providing assistance in the rationalization of facilities/services, and the education and training of physicians on improved quality assurance practices, methods and techniques.

This paper is submitted to provide a brief overview of some of the issues, problems, and opportunities available in the establishment of a National Mandatory Health Insurance Fund. It is not meant to be an in depth discussion of the subject, but is meant primarily to generate further discussion on some of the issues outlined.

This paper was developed and submitted by Michael Borowitz and George Purvis of the *ZdravReform* Program managed by Abt Associates Inc.

Attachment “A”

Normal Holding Company Oversight, Policy Formulation, and Decision Making Roles, Functions and definitions are as follows:

A. Policy Formulation: Policies are statements of intent that guide and constrain further decision making and action and limit subsequent choices. They reflect the values and preferences of the policy maker and convey expectations.

Examples of policy areas would be expectations of financial performance, quality of care, executive performance, and organizational performance.

Other policy areas might be a Mission Statement, a Corporate Business Plan, a list of Corporate Goals, a list of Services, a Marketing Strategy, an Organizational Plan, a Strategic Plan, Operating Plan, a short term and long term Financial Plan including a “Sources and Uses of Funds”, a Cash Flow Plan, an Investment Plan, a Capital Development Plan, a Personnel Plan including evaluation criteria of the Executive Officer, a Compensation Plan, a Pricing Strategy, Collection Strategy, an Equipment Plan, a Computer and Network Plan, a Quality Assurance and Control Plan, an Auditing Plan, and a description of the relationship between the National Mandatory Health Insurance Fund and the Oblast MHI Funds including reporting requirements and expectations of performance.

B. Oversight: Oversight usually entails three functions—monitoring, assessment, and feedback.

Examples of monitoring would be reviewing data and information submitted by the Oblast level Funds on the financial performance, cash flow, pricing, billing, collections, quality of care indicators, patient complaints, referrals, hospital admissions, etc.

Assessment usually refers to quantitative and qualitative judgments of the organizations performance on various issues according to developed policies and standards.

Feedback provides the information needed to modify existing policies and formulate new ones. Often initial projections, forecasts, guidelines and policies are not relevant to existing situations and may need to be modified.

NATIONAL MANDATORY HEALTH INSURANCE FUND ORGANIZATIONAL AND MANAGEMENT STRUCTURE

Outlined below is a description of the management, and organizational structure of the National Mandatory Health Insurance Fund (NMHIF) as outlined by the Director General.

Board Structure and Organization

The Supervisory Council of the National Mandatory Insurance Fund is composed of the following:

The National MHI Fund will have a National Supervisory Council, with a broad membership consisting of key government leaders (Vice Premier, representatives of the Cabinet, Ministry of Health, Ministry of Finance), and trade union leadership.

The Supervision Council will meet once or twice a year, and will review the operations and financials of the Fund.

Executive Structure and Organization (see Exhibit A)

The executive structure and organization of the NMHIF will consist of the following departments, functions, and positions:

A. Director General and Chief Executive Officer:

The Director General will be the senior manager of the Fund, will oversee all the activities and functions of the Fund, and will report to the Vice Premier and the NMHIF Board. The responsibilities of the Director General include the overall planning, organizing, staffing, directing, and controlling of the Fund, and includes the protection of the fiscal integrity of the Fund, the general management and administration of the Fund, and the payment for services by the Fund.

B. Deputy Director of Finance

The Director of Finance will be the Chief Financial Officer and Deputy Director of the Fund, and will be the senior financial manager of the Fund, will oversee all the financial activities and functions of the Mandatory Health Insurance Fund, and will report to the Director General. The Director of Finance will be responsible for all “sources and uses” of funds, ensuring that all premiums are collected, that all payments are made to providers, will manage the allocation of surpluses, and ensure the various financial and accounting functions are carried out according to law.

C. Deputy Director of Medical Affairs

The Director of Medical Affairs will be the Chief Medical Officer and Deputy Director of the Mandatory Health Insurance Fund, will be the senior medical manager of the Fund, will oversee all of the Health and Medical activities and functions of the Fund, and will report to the Director General. The Director of Medical Affairs/Activities will be responsible for all Quality Assurance, Utilization Review, establishment of all Medical norms, standards, and protocols and the development of Pricing for all services provided by the Fund.

D. Deputy Director of Legal Affairs

The Director of Legal Affairs will be the Chief Legal Officer and Deputy Director of the Fund, will be the senior legal officer of the Fund, and will report to the Director General. The Director of Legal Affairs will oversee activities related to changes in legislation, protection of the interests of the Fund, and ensure the protection of the interest of the general population.

E. Deputy Director of Administration and Support Functions

The Director of Administration and Support will be a Deputy Director of the Fund, will oversee all administration and support functions and activities and will report to the Director General.

F. Executive Committee

The Director General of the MHI Fund plus the four Deputy Directors (Financial, Legal, Medical, and Administration/Support) will constitute the “Executive Committee” of the Fund, will meet weekly, and will oversee the general management of the Fund taking executive decisions as required in order to ensure effective and efficient management of the Fund.

G. Budget for Management and Administration

The provision of budget for overall management and administration activities of the MHI Fund is based on an allocation of 2.8 percent of the total budget of the Fund, and positions for these activities are based on a guideline of one staff member per 10,000 population.

Oblast Level Management Structure and Organization (see Attachment B)

The general guidelines for the management structure and organization of the Mandatory Health Insurance Fund (MHIF), at the Oblast level are as follows:

A. Department of the General Director

The head of the MHIF at the Oblast level will be General Director, who will be the Chief Executive Officer, and will be responsible for all management and organizational activities and functions of the Fund on the Oblast level. The General Director will be responsible for all of the planning, organizing, staffing, directing, and controlling functions and activities of the Fund, as well as ensuring the fiscal integrity of the Fund and provision of payment for services by the Fund.

B. Department of Finance, Planning, and Economics

The Oblast MHIF Finance area will be headed by a Deputy Director for Finance, Planning, and Economics and will oversee all the financial activities and functions of the Fund, and will report to the General Director. The Director of Finance will be responsible for all “sources and uses” of funds, ensuring that all premiums are collected, that all payments are made to providers, will manage the allocation of surpluses, and ensure the various financial, planning and economic functions. It is envisioned that this department will consist of approximately five positions plus the Deputy Director.

C. Department of Accounting and Bookkeeping

The Department of Accounting and Bookkeeping will be responsible for ensuring that all accounting and bookkeeping activities, as required by law, are carried out. It is estimated that this department will have approximately three positions.

D. Department of Insurance

The Department of Insurance will be responsible for all activities and functions related to insurance. It is estimated that this department will have approximately six positions.

E. Department of Medical Affairs

The Department of Medical Affairs will be headed by a Deputy Director, will oversee all of the health and medical activities and functions of the MHI Fund, and will report to the General Director. The Director of Medical Affairs will be responsible for all Quality Assurance, Utilization Review, Medical norms, standards, and protocols and the development of Pricing for all services provided by the Fund. It is estimated that this department will have approximately five positions

F. Department of Information Systems and Computers

The Department of Information Systems and Computers will be responsible for the collection and reporting of all data, information, and statistics required by the Fund to oversee the effective and efficient management of the Fund. It is estimated that this department will have approximately four positions.

G. Department of Legal and Support Services

The Department of Legal and Support Services will be responsible for all of the support and legal functions and activities of the MHI Fund. It is estimated that this department will have approximately four positions.

H. Branches in Rayons

It is also envisioned that some Rayons will need branch offices of the Oblast level Fund.

I. Staffing

The guideline for staffing of positions will vary by Oblast, based on the guideline of 1/10,000 population.