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TRIP REPORT NO. CAR/KAZ-22

ORGANIZATIONAL DEVELOPMENT OF THE NATIONAL MANDATORY HEALTH INSURANCE FUND AND THE PHOSPHORUS HMO IN SKO

**Shymkent, Kazakstan
November 26–December 20, 1995**

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

AID Contract No. CCN-0004-C-00-4023-00
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EXECUTIVE SUMMARY

The development and implementation of 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 entire country. Coincident, 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 Phosporus 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 major part 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 Zdrav Reform 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 were presented and well received in the areas of MHIF payment systems, information systems, rationalization, restructuring, and quality assurance, as well as board and management issues.

The second part of the trip was the work 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 and assisting with the prioritization of activities and development of assignments to complete the work on time. Additional work was done on developing recommendations on the board, 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 Abt personnel and the counter parts believe that this can be accomplished within the time frame outlined. 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 where 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 (Phosporus, Emergency, and City Hospital #2) in Shymkent. Considerable work has gone into the pre-planning of the HMO 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 April of 1996.

The work with the 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 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 Section of this report:

OBJECTIVES

The objectives for this trip are outlined in the consultant's SOW (see annex) 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 outline the Technical Assistance required from them by the Zdrav Program to ensure the effective development and implementation of the fund;
3. To work with the new Phosporus Hospital HMO management team, and the IDS Abt advisors, consultants and counterparts, to develop a realistic and workable plan for implementation of the new HMO by April 1, 1996;
4. To develop a board 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, as discussed by the Director General of the Fund and as envisioned by the Zdrav Reform Project. Furthermore, the paper outlines the technical assistance programs which may be implemented over the next three years.

The Zdrav Reform Project, managed by Abt Associates, 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 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.

VISION

The National Mandatory Health Insurance Fund 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.

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.

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.

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 in 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

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. Appendix A 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 Appendix A. 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

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 Kyrgystan.

PAYMENT FOR OUTPATIENT SERVICES

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, we recommend that FAP'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.

A. 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.

B. 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.

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 MHIF require 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 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. Appendix B 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, 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 good 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 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.

RATIONALIZATION AND RESTRUCTURING OF THE HEALTH SYSTEM

As previously highlighted in a number of papers, the health care delivery system of Kazakhstan, as with other CIS countries, has an *over* supply of facilities and *excess* personnel. Rationalization of facilities is necessary in order to generate 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 funds “rationalize and restructure” the existing health care delivery system.

In order to take advantage of the new payment systems and 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 Felsher 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 just 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 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 more expensive polyclinic and hospital care. This process will 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). This will mean that some providers will become independent of the Department of Health and will be able to focus more on their own future activities. This 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.

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:

1. 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.

2. 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. The 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 the patient receives appropriate care which is also high quality and cost effective.

3. 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.

4. 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 will only pay for medications and pharmaceuticals that are included in this list. This is presently underway in a number of the Oblast demonstrations areas

5. 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 facility which is licensed will be able to receive the standard MHIF payment rates.

ATTACHMENT A

HOSPITAL PAYMENT SYSTEMS

I. BACKGROUND

The hospital payment system in Kazakhstan is a budget system in which the hospital is allocated a fixed amount of funds to operate for a year. The budget is inflexibly partitioned according to budget chapters. As the budget system allocates funds based on production input measures such as number of beds, it contains a direct financial incentive to increase and maintain capacity. The result is a health service delivery system with too many hospitals and too many beds. This form of hospital payment provides no incentives for efficiency, and in so far as the chapters prevent the flexible use of funds, the payment system actually inhibits the efficient use of resources.

Market oriented hospital payment systems typically provide a payment for the production of a defined unit of hospital output. They strengthen the connection between the type, level and quality of services provided to an individual patient and the amount of financial reimbursement received by the hospital. Some payment systems are per diem systems, providing a set payment for each day spent in the hospital. Other systems are per case systems, providing a set 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. It is intended that an efficient hospital make a profit on some cases and lose money on other cases, not that the payment match the costs of each patient. A payment based on average cost is optimal because the variety of patient requirements is so vast and the technology for the production of health care changes so quickly that any attempt to match payment with the treatment provided to each patient would be counterproductive.

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. These incentives have been found to have measurable effects on LOS throughout the world, including recent experience in the Ukraine. 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.

Providing incentives for efficiency is useless unless managers are simultaneously given authority and the ability to reduce costs. The case-based hospital payment system assumes that managers of individual hospitals will have control over staff hiring, firing, salary decisions, and purchases of drugs, supplies, and all other items needed by the hospital.

II. METHODOLOGY FOR CASE-BASED HOSPITAL PAYMENT SYSTEMS

A per diem hospital payment system consists of a payment per bedday for a number of categories defined by medical specialty or LOS. Each per diem category is given a relative weight based on its cost as compared to the average cost for all beddays. Payment to a hospital for a bedday is proportional to the weight for the category to which the patient is assigned. The hospital payment amount is determined prospectively and consists of a base rate multiplied by the relative weight for the per diem category containing the patient.

The specific steps required to develop a per diem hospital payment system are as follows (ZdravReform has also developed the steps for a case-based hospital payment system):

1. Collect financial, capacity and utilization data from all hospitals for both the entire hospital and each department. The data sheets each hospital should submit are attached as Exhibit One.

The financial data consists of the budget chapters. Capacity data is beds and staff. Utilization data is both hospital outputs such as beddays and discharges, and intermediate services such as lab tests and x-rays.

2. Utilize a cost accounting system to calculate unit costs per bedday for each clinical department. A hospital cost accounting worksheet is attached as Exhibit Two.

Hospital clinical departments, for example cardiology, produce final outputs and receive revenue from customers. The cost accounting system contains a step down cost allocation which allocates both direct and indirect costs of administrative and paraclinical departments to clinical departments. This ensures that all hospital costs are included in the cost of the outputs -- defined as beddays and discharges. It is important to note that while the amount of data collected in Kazakhstan is fairly substantial, the weakness of the data collection process is that utilization and financial data are not combined to obtain the cost per unit of service.

An important part of the cost accounting process is to separate the costs of outpatient services from inpatient services. This is accomplished by allocating to polyclinics their portion of the combined facility costs. Other costs not attributable to inpatient care, such as central accounting systems for central rayon hospitals, are also allocated. Finally, policy decisions may result in costs such as consultative care or ambulance services not being part of the competitive hospital payment system (remaining on budget). They should be removed and reimbursed separately. Following the cost allocations, all the inpatient hospital costs are summarized. This determines the amount of total health sector resources for inpatient care, and is used to calculate the base rate for the hospital payment system.

3. Construction of the per diem categories

Constructing the per diem categories requires evaluation of costs or resource use across medical specialty. The result of this evaluation should be the identification of approximately 5-10 per diem categories which. They should be easily distinguishable and reflect the existing flow of patients as defined by the structure of the hospital departments.

4. Estimation of costs for the per diem categories

If any of the categories cross hospital department lines or break a hospital department into two per diem categories, this step allocates costs to each of these categories. The methodology would vary depending on the nature of the per diem category.

5. Construction of a relative weight for each per diem category and the base rate for the hospital payment system.

Costs assigned in step four are summarized across all hospitals for each per diem category. The relative weight for a category is calculated by dividing the average cost for a bedday in each category by the average cost for all beddays. The average weight for all beddays is 1.0. The system of relative weights for all per diem categories can be used with any base rate. The base rate for the hospital payment system is calculated by dividing the total estimated pool of both budget funds and employer premiums by the total estimated number of beddays.

6. Simulations to compare and analyze the revenue received by each hospital under the old budget system and the per diem hospital payment system.

After the relative weights and base rate have been calculated, a simulation or comparison of the payments to hospitals under the old budget system and the per diem system is constructed. In the simulation, each hospital is paid using the relative weights for the per diem categories and the base rate for all beddays in a baseline year, probably 1994. An analysis of how the hospital performs under the new hospital payment system is done for both the entire hospital and individual departments.

7. Analysis, education, and training for hospital managers about the new payment system.

Management autonomy is needed for the hospital managers to respond to the financial incentives of the new payment systems. This step also includes examination of the results of the simulation showing how the hospital performs under the new hospital payment system.

ATTACHMENT B

AVAILABLE IN RUSSIAN ONLY

THIS IS A COMPUTER FLOW DIAGRAM

ATTACHMENT C-1

METHODOLOGY FOR RATIONALIZATION OF HEALTH FACILITIES

Outlined below is a methodology that would assist the Oblast level funds, through training a core group of managers, to rationalize their existing facilities within the first year of the new insurance program:

A. THE RATIONALIZATION PROCESS:

There are five (5) essential steps in the rationalization process for health facilities and services:

1. **Collection of the required data needed;**
2. **A visit to each facility with an information questionnaire;**
3. **Analysis of the data and information collected;**
4. **List of Findings and Recommendations.**
5. **Presentation and Implementation**

STEP #1: DATA REQUIRED

At the beginning of the process it is important to collect the following data and information:

1. A list of the various facilities (by type, location, size, list of services provided ,etc.);
2. A list of the workload (bed days, outpatient visits, etc. by department);
3. A list of the staffing (physicians, nurses, other by inpatient and outpatient and by department);
4. A list of budget and actual expenses and revenues;
5. A list of the various morbidity and mortality data
6. A detailed map of the area.

STEP #2: INFORMATION QUESTIONNAIRE AND VISIT TO EACH FACILITY

A list of key questions and a list of the information to discuss with the Chief Physician of each facility should be developed - see example in Exhibit A at end of this Attachment

1. The key ingredient to a successful visit is to have reviewed some of the information in step #1 ahead of the visit. This will help the reviewer ask the pertinent questions about workload, staffing, productivity, services, quality, equipment, maintenance, etc. In visiting the facility, the reviewer should begin by sitting down with the Chief Physician and review the questionnaire.
2. One of the most important parts of the visit is a tour of the entire facility, including all ancillary departments, sections, rooms, wards, bathrooms, toilets, floors, and out buildings not attached to the main building. By visiting each section and each department you can question staff about workload, staffing, quality, and problems unique to their department. You can observe first hand how many patients you see, what condition the equipment is in, what supplies and materials are in short supply, and how busy the staff is with patients. You should observe and note the condition of

the building, the maintenance, water damage, equipment use or non-use, heating, electrical systems, water and sewage systems and other building resources.

3. The tour will give you an excellent opportunity to note the diagnostic and treatment capabilities of the facility, as well as the acuity of patients. Talk with patients about their assessment of the conditions, staff, facilities, food, medications, and quality of care, as well as their social welfare and well being. The tour will allow you to talk with physicians in each section about their perceptions of equipment, staff, medications, instruments, quality of care, length of stay, workload, productivity, cost, maintenance, and management of the institution.

STEP #3: ANALYZING THE DATA AND INFORMATION COLLECTED

After your tour you should return to the data previously collected and review any inconsistencies you noted. It is important to begin calculations of key indicators of cost/per unit, cost/department, cost/budget chapter, workload by department, productivity of personnel by department, disease trends, mortality/morbidity indices, trends in workload and staffing, inpatient vs outpatient costs, and other key indicators of financial and quality performance. Broad analysis about quality, cost and access are required, as well as specific analysis about the condition of individual facilities. The analysis should cover all areas of management, finance, quality, access, cost, productivity, workload, staffing, pharmaceuticals, equipment, medical instruments, supplies and materials.

STEP #4: FINDINGS AND RECOMMENDATION

Upon reviewing the data collected and the information from the visit to each institution, you should begin to write down possible findings and recommendations. It is helpful to group these recommendations into financial, quality, management, building, equipment, etc. areas so that they will be more meaningful when presented. You will also note similar problems at all institutions, at smaller facilities, inpatient and outpatient area, and general themes which flow across all areas. You will want to include the possibility of closing, merging, consolidating, improving, enlarging, and expanding facilities and services

STEP #5: PRESENTATION AND IMPLEMENTATION

The final steps are the write up and presentation of your findings and recommendations. This is always the most difficult part of the process and the one that is the most critical. Building in some type of evaluation process is also important so that it is possible to determine if the changes had the effect or impact that you desired.

EXHIBIT A: LIST OF KEY QUESTIONS FOR HOSPITAL VISITS

NAME OF FACILITY:

NAME OF INTERVIEWEE:

PHYSICAL PLANT:

Number of Total Beds/Number of Beds in Service:
Number and Types of Buildings:
Age, Type and Condition of Physical Plant/ Heating/ Water/Sewage/Trash/Garbage Systems:
Type and Condition of Medical Equipment:

SERVICES AND PROGRAMS

Catchment/Service Area/Type of Population:
In-Patient and OutPatient Services/Programs:
Number of Beds by Service, including Specialty Beds::
Days/Hours of Operation for clinics:
Referrals to/from other Hospitals:
Ambulance Services:
Laboratory and Radiology Services:
Primary Health Care Programs:

WORKLOAD AND KEY PATIENT ACTIVITY

Total Patient Days/Days by Service:
Total Admissions/Discharges/Occupancy-(Total and by Service):
Length of Stay - (Total and by Service):
Deliveries/Operations/Surgery (In and Out-Patient):
Major changes since independence (closed beds/services:)

CLINICAL/MEDICAL

Most Common Diseases/Admissions/Morbidity/Mortality Indicators:
Environmental Health Concerns:
Season Patterns to Diseases/Patient Behavior:

PERSONNEL

Number of Physicians/Number of Nurses:
Number of Other Staff/Total Staff:
Administration/Management/Supervision::
Accounting/Financial:

BUDGET

Total 1994/95/By Chapter:
Drugs and Pharmaceuticals:
User Fees:
Estimated % IP vs OP cost:
Estimated % of Total Cost which are Personnel:
Private Practice activities:

OTHER ISSUES:

Biggest Problems:
Strengths/Weaknesses of institution:

ATTACHMENT C-2

METHODOLOGY FOR RESTRUCTURING OF THE HEALTH SYSTEM

Outlined below is an abbreviated methodology that would assist the Oblast level funds bring about a “restructuring” of the health delivery system:

A. REFOCUSING MORE RESOURCES INTO PRIMARY MEDICAL CARE

The introduction of new payment systems should bring with it capitation based systems that focus more attention on prevention and primary medical care. The existing health care delivery system has a shortage of primary care physicians (internists, Ob/Gyn, Pediatricians), and those practicing primary care do not diagnose and treat patients, but usually refer patients to specialists and subspecialists in the polyclinics. While the reasons for this are varied (lack of equipment, little diagnostic capabilities, few medications, etc.), it will be necessary to focus more resources into delivering improved methods of primary medical care if the health care delivery system is to operate more cost effectively.

Successes in other CIS countries have shown that restructuring is possible by assisting primary care physicians set up Primary Group Practices (PGP) and Family Group Practices (FGP). This requires providing assistance to these physicians in moving out of the polyclinics and in getting set up in groups to work together in treating the total health care needs of the family. This is the concept known as “Family Medicine”. This will result in fewer referrals to specialists, polyclinics, and fewer admissions to hospitals. This requires training and education, as well as funds for minor equipment, medications, and improving diagnostic capabilities. All of this can be done through changes in the payment system, by capitation type systems which reward certain types of behavior and discourage other types of behavior.

B. FORMING MULTISPECIALTY POLYCLINICS

The changes in payment should allow specialists, subspecialists, and superspecialists to form multispecialty polyclinics. This means that these physicians would form multispecialty groups that would handle those referrals from the primary care physicians in a more cost effective manner. Assistance to these groups would be needed in training, education, and other areas of improving diagnostic and treatment capabilities, as well as improving levels of management and financial autonomy for these multispecialty polyclinics from the hospitals and from the Department of Health.

C. NORMS, STANDARDS, AND TREATMENT PROTOCOLS

The existing health system relies heavily on norms and standards. There are norms for the number of physician visits by specialty type, norms for complexity groups, norms for LOS by disease type, and medication and nutrition norms. While the concept of norms and standards is critically important from a scientific and professional standpoint, it can become a significant deterrent to improved productivity, especially in an environment that requires everyone to do more with less.

This is the classic “scientific management” approach which worked effectively in the period from 1920-1970’s. However, norms keep personnel from striving for greater productivity and personnel feel that if they achieve the standard they can then relax and need do no more. Standards imply there is only “one best way” to do things and everyone only needs to learn and to apply these standard methodologies. The most significant change in the area of quality assurance, quality control, and cost/quality improvement over the last ten years has been a movement away from rigid standards toward a more open, more questioning, more “try it, do it, fix it” approach.

These norms and standards are especially apparent in the treatment of some diseases including TB and STD. Treatment protocols in other developed countries have moved toward almost exclusive treatment on an out-patient basis of these diseases. A review of the data and discussion with physicians has shown that patients are treated as inpatients and kept for long periods of time. While this may be correct procedure in a system with many resources, it is a waste of critical resources. The issue is less the method of treatment and more the issue of trying to find new ways to provide the services and treatment more cost effectively.

D. THE CONCEPT OF THE GENERAL HOSPITAL

The old Soviet Health Care System was built on the concept of many different specialties, subspecialties, and superspecialties, as well as the concept of many different types of hospitals with smaller, single buildings for each special disease type. From a productivity standpoint (capital, facility, equipment, and personnel) this system results in low productivity and duplication of equipment, personnel, and facilities. Other developed countries outside the old USSR, have moved toward the concept of a “general hospital” with various specialties becoming departments of one major facility. In this way all specialties can share the same critical mass of ancillary services (laboratory, radiology, physical therapy, pharmacy, etc.) and plant equipment (heating, water, sewer, etc.) and exploit economies of scale and scope, and achieve significantly higher productivity in all areas.

ATTACHMENT D

**(this is not related to the above topics and was presented as a side interest
of the Director General for the Vice Premier)**

THE CASE AGAINST A “PERSONAL” NATIONAL HEALTH ACCOUNT

In the early stages of setting up National Mandatory Health Insurance Funds in some countries, the idea of a “personal” national health account is frequently mentioned. This idea has come out of the American experience, which has thousands of different private and public health insurance policies, programs and insurance companies. These funding vehicles are often called “Medical Savings Accounts” or MSA’s for short.

The basic concept of a MSA is an attractive idea, and in the simple form is similar to a personal savings account at a bank, where each person in the country would have funds added to their account on a regular basis, either by their employer or by the government. These funds would be available only for health and medical needs and would be utilized as the person sees fit. The basic belief is that each person would be more responsible for their own health services, being careful only to spend that amount which they feel necessary, and thus only buying services that are really necessary. The concept, while basically attractive, has a number of problems and negates many of the concepts of insurance as outlined below:

1. The basic concept of buying health insurance, usually on a pre-paid basis through small monthly payments over a long period of time, is to provide the insured person or family protection against a catastrophic illness or medical event (heart attack, cancer, accident). With an MSA, the person or the employer, or the government would still have to purchase a catastrophic insurance policy to cover the possibility of this type of event.
2. The utilization of health services varies greatly by age and by sex. We know that children up to age of 14 usually use significant health services, but after 14, except for pregnancy, most people do not utilize very many health care services until the age of 50. From the age of 50 to death, most people utilize the greater majority of health services they will use in their entire lives. With an MSA the individual may be in a deficit situation during the ages of 0-14, would then possibly go into a positive balance sometime between age 14-50, and then would quickly exhaust their “savings” sometime before their death. Paying for periods when the account is in deficit or is exhausted near the time of death, would require an additional employer, insurance or government program.
3. The basic idea of people using less health care and being more careful with spending their “savings”, only purchasing health services when really needed, and then seeking out the best value for their money, thus controlling utilization, is also a flawed concept. While this sounds attractive, we know that prevention and early detection of disease is much more cost effective than late stage detection of disease. Immunization programs and seeing the doctor when early signs of illness occur has proven over time to be more effective. With an MSA program, the individual may think

twice about spending the funds and would not see the physician early enough to allow early detection and treatment of the disease, thus leading to more costly treatment in the later stages.

4. Another major criticisms of MSA's are the issues that the employer or the government may not handle these "surplus" accounts in a financially conservative way, and may take these funds for other needs. Other issues have to do with the taxability of these accounts, as well as if the employee can borrow against the account for other reasons, or gets to keep the balance or some of the balance upon leaving the company or retiring.

While the major proponents of these MSA accounts usually stress the possible "cost consciousness" and "cost containment" factors, these have been proven to be insignificant in the overall administration of a health insurance program.

B. 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 Zdrav Reform.

NATIONAL MANDATORY HEALTH INSURANCE FUND: ISSUES, PROBLEMS AND RECOMMENDATIONS

I. 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 Zdrav Reform Project, World Bank, and others working in the South Kazakhstan Oblast, Dzhezkazgaz , Issyk-Kul Oblast in Kyrgyzstan, and other CIS countries.

II. Existing Health System Problems

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

1. The medical delivery system is dominated by hospitals, with approximately 70% of the funding going to hospitals, and only 30% 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 3-5 times the acceptable rate of other countries.
4. The number of physicians per bed, nurses per bed, total employees per bed are 2-3 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.

III. Existing Health System Opportunities

The experiences of Zdrav Reform and the World Bank in a number of the CIS countries have 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, Zdrav Reform, and local community experience.

IV. Recommendations for National Mandatory Health Insurance Fund

Based on the experience of other CIS countries, and specifically on the Zdrav Reform and World Bank projects, the following recommendations are submitted for consideration in the development of the National Mandatory Health Insurance Fund of Kazakhstan:

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 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 funds, with oversight and monitoring by the National Fund.
4. A central role of the National 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 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 Zdrav Reform program operated by Abt Associates.

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”, Cash Flow Plan, an Investment Plan, a Capital Development Plan, a Personnel Plan including evaluation criteria of the Executive Officer, a Compensation Plan, 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 Fund and the Oblast 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.

C. 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.

I. Board Structure and Organization

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

The 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.

II. Executive Structure and Organization (see Attachment 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 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 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 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 fund is based on an allocation of 2.8% 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.

III. 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 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 Fund. It is estimated that this department will have approximately four positions.

H. Branches in Rayons

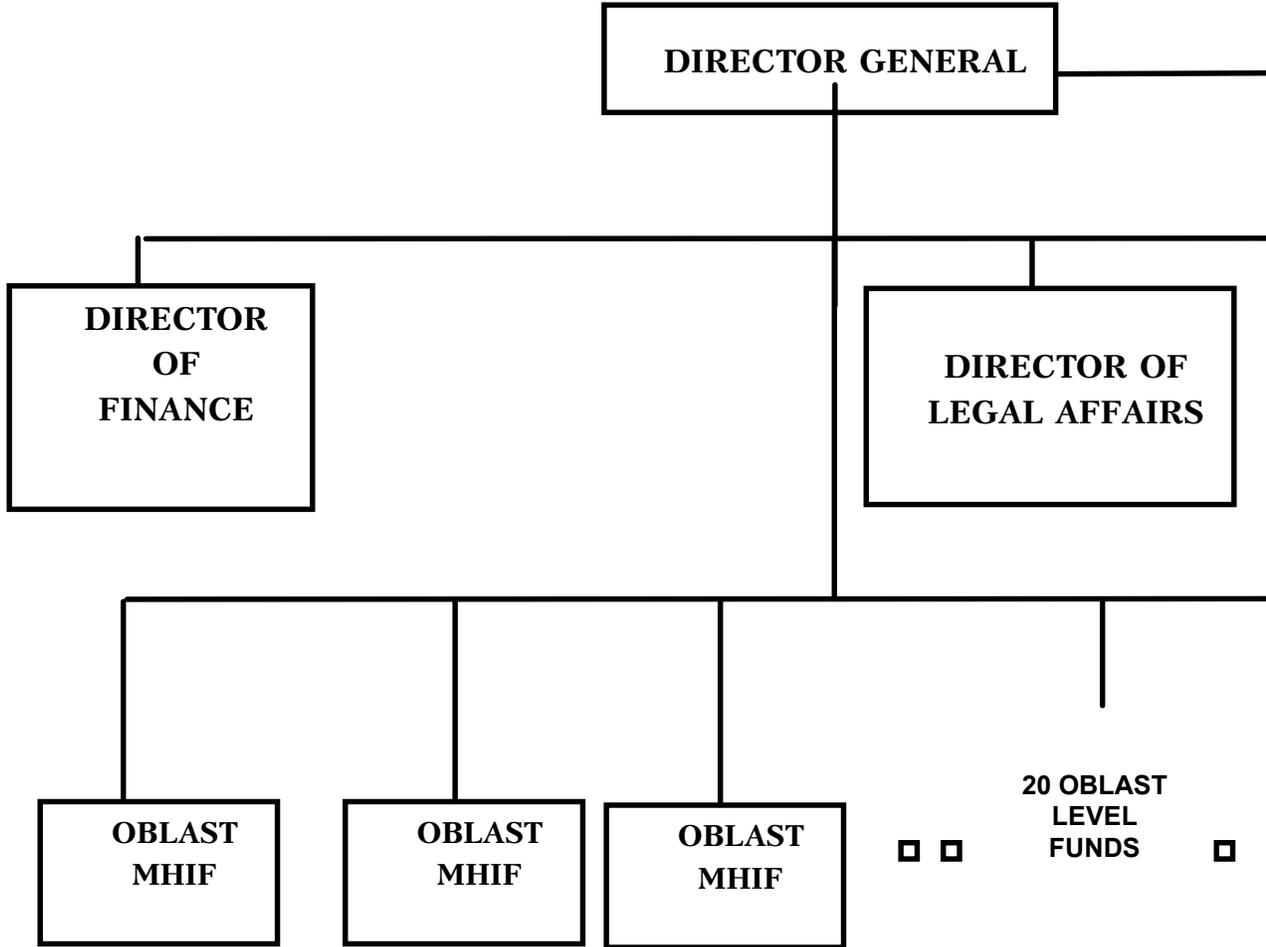
It is also envisioned that some Rayons will need branch offices of the Oblast level Fund.

I. Staffing

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

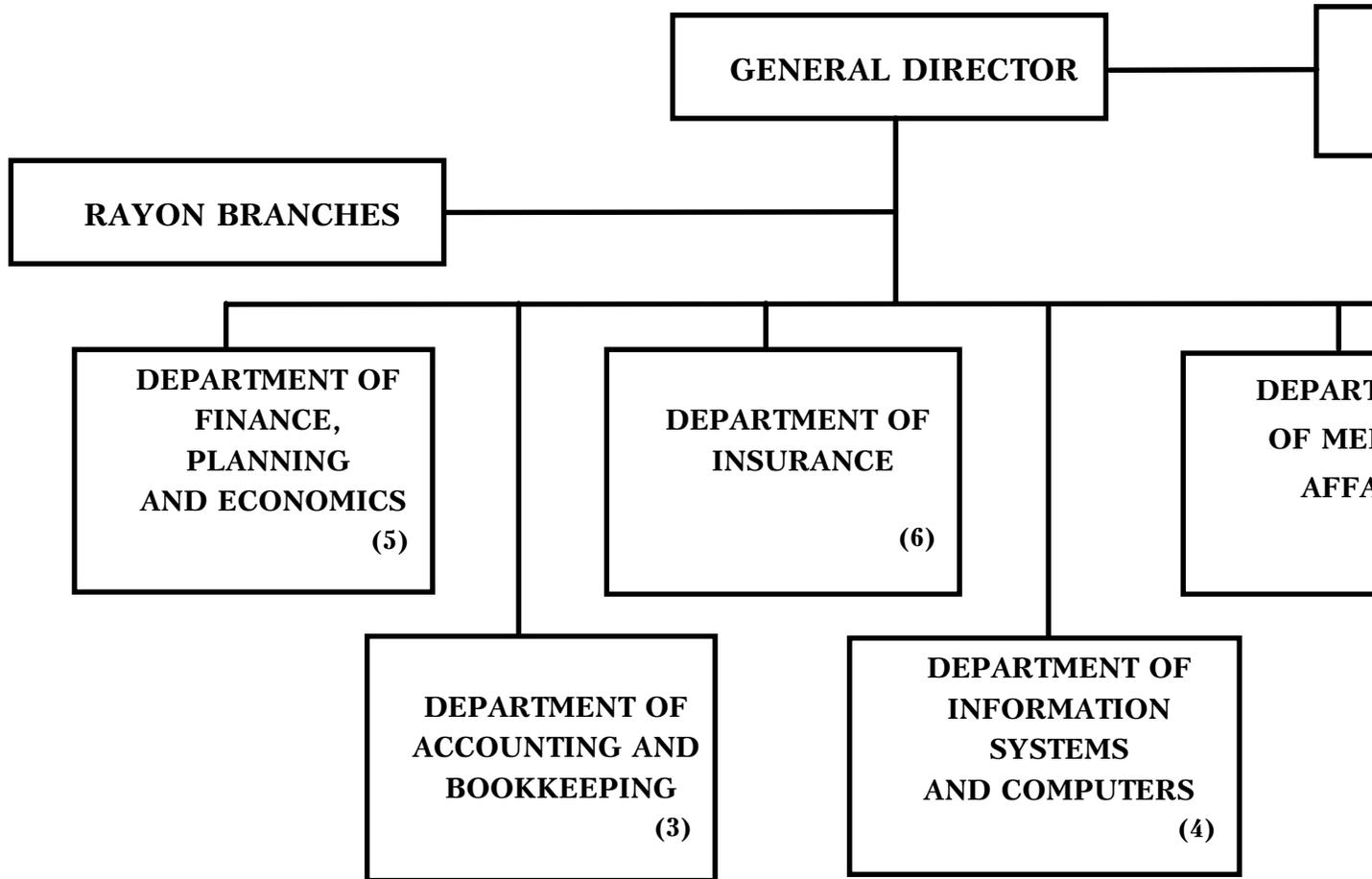
Attachment A

National Mandatory Health Insurance Fund (NMHIF)



Attachment B

Oblast Mandatory Health Insurance Fund



D. THE SHYMKENT HMO

1. BACKGROUND

The development of a hospital based HMO in Shymkent has been under consideration since March 1995 (see Annex B). Considerable effort, both consulting and Abt staff, has gone into the planning and development stages of the project. The Phosphorus Hospital was chosen for the demonstration due to its progressive management of the hospital, the leadership of the MHIF, the interest of Kabisco Corporations, to the large polyclinic catchment area now served by the hospital. It was believed that the Phosphorus organization would provide the best environment for establishing, developing, and successfully implementing an HMO in the SKO-IDS.

However, the history of hospital based HMO in the US and other countries has not been very positive. With the exception of the Kaiser organization, which is not really a strict hospital based HMO, the experience has not been overwhelmingly favorable. Most hospital based HMO have spun-off, sold, merged, or disbanded their own HMO'S due to inherent conflicts between the normal goals of an HMO and the normal goals of a hospital. Traditionally, hospital management has been interested in filling their beds and utilizing large amounts of profitable ancillary services. HMO's are interested in emptying the beds and reducing utilization of ancillary services. Hospitals are interested in maximizing their charges to patients, insurance carriers, HMO's, etc. and HMO are interested in a big discounts for giving hospitals lots of patients. Many hospital professionals consider HMO's nothing but "Utilization Review with a Discount". This basic dichotomy of goals has seldom been successfully bridged, regardless of what some managed care personnel will profess. A review of the literature will show that the experience of hospitals running HMO's successfully has been very mixed. While there have been some exceptions to the above experience, they have usually been in healthy, growing markets, where managed care goals are in congruence with the hospital goals. This does not mean that the Shymkent HMO is not a viable idea, but it does mean that care must be taken to structure the systems both the hospital and the HMO to reward and not penalized acceptable hospital behavior.

During the last three months of the project, the thinking has changed to delete the "hospital based" idea and to make the HMO into a "city wide" HMO serving a larger area and not having the problems of hospital based, as outlined above. This appears to be a much more viable concept with greater flexibility and greater potential for development. The attached workplan is outlined to meet this changing environment.

2. WORKPLAN

The overall workplan as outlined below was developed by Alexander Telyukov and is a comprehensive list of all of the activities necessary to get the HMO operational and functioning as designed. The original time frame of getting the HMO up and operating by April 1st of 1996 is highly aggressive, ambitious, and will be difficult to achieve considering the present difficulties of the environment. Outlined below is a revised schedule of events, highlighting the priority items (**deliverables and dates listed in brackets**), which need to be done before opening

day, and those which may be delayed until some later date after opening day:SHYMKENT
HMO WORKPLAN

ACTIVITY	PRIORITY	NON-PRIORITY
1.0 LEGAL AND CONTRACTUAL (dates of projected completion are shown in brackets)		
1.1 The Phosphorus HMO Charter		
1.1.1 Drafting initial text	X	in-process
1.1.2 Review and revisions	X	(12/20/95)
1.1.3 Adoption by Oblast Administrator	X	(1/15/96)
1.2 The HMO Contract with MHIF		
1.2.1 Drafting initial text	X	in-process
1.2.2 Review and Revision	X	(12/20/95)
1.2.3 Approval of Contract	X	(1/15/96)
1.3 Contracts with Providers		
1.3.1 Draft initial text	X	in-process
1.3.2 Individual institution adjustments	X	(2/15/96)
1.3.3 Review and Revision	X	(2/22/96)
1.3.4 Negotiation and Approval	X	(3/1/96)
1.4 HMO Membership Agreements		
1.4.1 Draft initial text	X	in-process
1.4.2 Review and Revision	X	(3/1/96)
1.4.3 Signed Agreements	X	(3/15/96) first 1000 members
2.0 INTERNAL MANAGEMENT RULES AND PROCEDURES		
2.1 Internal Management Systems		
2.1.1 Governing Board Rules and Regulations	X	(12/23/95)
2.1.2 Functions and Duties of Executive Directors	X	(12/23/95)
2.1.3 Nominations for board members and directors	X	(12/25/95)
2.1.4 Formation of the Board and Management	X	(1/15/96)
2.2 HMO Internal Legal Relationships		
2.2.1 Criteria for Provider Selection		X (6/1/96)
2.2.2 Resolution of Disagreements		X (6/1/96)
2.2.3 Rules of Redress for Members	X	(4/1/96)
2.3 Standards Procedures for Management		
2.3.1 Human Resources Policies and Procedures		X (7/1/96)

2.3.2	Budget Planning and Control Procedures	X	(7/1/96)
3.0	CLINICAL PLAN		
3.1	Mission, Goals, and Objectives		X (6/1/96)
3.2	Formulate Clinical and Organizational Standards		
3.2.1	Itemized list of services in benefit package	X (2/1/96)	in-process
3.2.2	Estimating Utilization Patterns	X (4/1/96)	
3.2.3	Estimating Utilization Reductions	X (2/15/96)	
3.2.4	Estimating Referral Changes		X (6/1/96)
3.2.5	Adjusting Utilization Rates		X (7/1/96)
3.2.6	Clinical Standards for High Volume Services		X (5/1/96)
3.3	Pharmaceutical Standards		
3.3.1	Develop InPatient Drug Formulary	X (1/15/96)	In-Process
3.3.2	Develop OutPatient Drug Formulary	X (1/15/96)	In-Process
3.4	Development of Quality Assurance Program		
3.4.1	Develop Indicators of Quality		X (6/1/96)
3.4.2	Rights and Duties of HMO on QA		X (6/1/96)
4.0	BUDGET AND BUSINESS PLAN		
4.1	Implement Cost Accounting Systems		
4.1.1	Develop provider cost centers		X (9/1/96)
4.1.2	Identify apportionment criteria		X (9/1/96)
4.1.3	Develop Statistical Database		X (9/1/96)
4.1.4	Adjusting formulas to fit Providers		X (9/1/96)
4.1.5	Enter data and present output		X (9/1/96)
4.2	Procedure Costing for High Volume Services		
4.2.1	Estimating Department Direct Costs		X(10/1/96)
4.2.2	Estimating Department Indirect Costs		X(10/1/96)
4.2.3	Estimating Overhead		X(10/1/96)
4.2.4	Projecting Drug Costs		X(10/1/96)
4.3	Calculation of HMO Capitation Rate		
4.3.1	Aggregating unit costs and utilization rates	X (3/1/96)	preliminary only
4.3.2	Loading net rate to estimate gross rate	X (3/1/96)	preliminary only
4.4	Develop HMO Budget and Business Plan		
4.4.1	Estimated Projected Enrollment	X (3/1/96)	open enroll 2nd yr
4.4.2	Negotiating Capitation Rate with MHIF	X (3/15/96)	
4.4.3	Developing HMO Business Plan	X (2/1/96)	preliminary only

4.4.4 Developing HMO Budget X (2/1/96) preliminary only

5.0 HMO FINANCIAL AND ECONOMIC OPERATIONS

5.1 Retrospective Adjustments

5.1.1 Adjusting Production capacity X (1/1/97)
 5.1.2 Evaluating Alternatives X (1/1/97)
 5.1.3 Developing Structural/Operational Adjustments X (1/1/97)

5.2 Building the Logistics and procurement Systems

5.2.1 Organize Competitive Bidding X (1/1/97)
 5.2.2 Negotiate Contracts with Suppliers X (1/1/97)

5.3 Develop Billing and Payment Arrangements

5.3.1 Specifying Payment Method from MHIF to HMO X (3/1/96)
 5.3.2 Specifying Payment Method from HMO to Providers X (3/15/96)
 5.3.3 Developing Deposit and Transferring Procedures X (3/15/96)
 5.3.4 Selecting a Financial Institution X (3/1/96)
 5.3.5 Developing Sources and Uses of Funds X (2/1/96)

6.0 MANAGEMENT INFORMATION SYSTEMS

6.1 Designing Clinical, Economic and Financial Data Base

6.1.1 Developing OR Procedure Classification Systems X (1/1/97)
 6.1.2 Developing Diagnosis and Medical Classifications X (1/1/97)
 6.1.3 Developing the HMO Member Registration Form X (3/1/96)
 6.1.4 Design Discharge and Abstract Systems X (6/1/96)
 6.1.5 Design Billing and Collection Systems X (3/1/96)

6.2 Designing Data Base to Support MIS

6.2.1 Develop QC Module X (1/1/97)
 6.2.2 Develop HMO Member and Patient Registration Module X (4/1/96) manual only
 6.2.3 Develop Utilization Module X(10/1/96)
 6.2.4 Develop Clinical Patterns Module X(1/1/97)
 6.2.5 Develop Intensity and Productivity Module X(1/1/97)
 6.2.6 Develop Accounting Module X (4/1/96) manual only
 6.2.7 Develop Appointments Module X(12/1/96)
 6.2.8 Develop Billing and Payment Module X (4/1/96) manual only

6.3 Designing an HMO MIS to support IDB

6.3.1 Allocate Data Flows X(1/1/98)
 6.3.2 Assess Resource Needs to support MIS X(1/1/98)
 6.3.3 Plan activities for the MIS network X(1/1/98)
 6.3.4 Implementing the MIS Plan X(1/1/98)

7.0 MARKETING AND PUBLIC RELATIONS

7.1 Arranging Marketing Campaign

- | | | | |
|-------|--|------------------------|------------|
| 7.1.1 | Design and Print Ad's, Brochures, etc. | | X(1/1/97) |
| 7.1.2 | Design and Print HMO Membership Card | X (3/15/96) | |
| 7.1.3 | HMO TV and Radio Advertisements | | X (1/1/97) |
| 7.1.4 | HMO Presentation to Press | X (4/1/96) preliminary | |
| 7.1.5 | Work with target community on enrollment | | X (1/1/97) |
| 7.1.6 | Official Ribbon Cutting of the HMO | X (4/1/96) | |

7.2 Public Relations Programs

- | | | | |
|-------|--|--|------------|
| 7.2.1 | Recruit and Train Spokesperson | | X (1/1/97) |
| 7.2.2 | Design and Print Newsletter | | X (1/1/97) |
| 7.2.3 | Develop Strategy with National regulatory Agencies | | X (9/1/96) |

8.0 Documentation/Dissemination of Technical Product X (3/15/96)

While many of these activities can be delayed until after start up, of the full list of approximately 90 tasks to be completed, fully a third, or approximately 30 tasks need to be started and partially completed before the kick-off day of April 1, 1996. Knowing the difficulties in marketing and the development and negotiations of contracts, as well as the normal political and consensus style of decision making, this list of tasks to be completed will be very difficult to finalize by opening day. However, everyone believes this is possible given the excitement and enthusiasm of the project.

3. BOARD/MANAGEMENT ACTIVITIES

The various activities related to the development of a board and management team for the new HMO are as follows:

WORK ITEMS FOR THE HMO BOARD:

- The board membership will need to be decided and should probably be kept small, at not more than 9-11 members, with possibly three providers, three consumers, and three local government personnel, and 1-2 trade union members.
- The structure and membership for board committees and subcommittees needs to be outlined and developed.
- The board committees should consist of the normal oversight functions of Finance, Quality Assurance, Audit (both medical and financial), Community/Public Relations, and others as the need develops, as well as a small Executive Committee (3-5 persons) for timely decision making when the full board can not meet.
- The Board should probably have a non-voting position of "Secretary to the Board" to oversee, organize, distribute, and follow up on agendas, meeting , board papers, and other administrative functions of the Board.

- Board committees and subcommittees should be kept small, with 5-7 persons as official representatives, and various staff being added as unofficial members.
- The Board should have at least one member of the Mandatory Health Insurance Fund Board, in order to provide feedback to the MHIF board on policy issues.
- The HMO Board should bring in other members from the community, from industrial enterprises (including Kabisco), trade unions, Oblast Health Department, and others, in order to broaden the base of needed skills and background of the Board. This may be done as official members of the board or as unofficial members who could serve on committee or subcommittees. An example might be the Finance Committee, which would have the key board personnel as official members but may want to bring in non-board community specialist in insurance, capital development, etc.
- Other organizational and staffing issues are the development of job/position descriptions for all of the new and proposed positions for the board.

WORK ITEMS FOR MANAGEMENT:

- A key issue will be who and how many management personnel there will be and how they will be paid during the start up. It would be best to utilize known personnel from the existing organizations involved, at no salary during the initial stages. The key positions will be the Executive Officer, the Financial Director, and the Medical Director.
- Important tasks in the management area are the development of position descriptions, functions, and responsibilities of management committees and subcommittees.
- There are a variety of Board/Management issues such as distinguishing the different roles, responsibilities and authority of each element of the governance/management process.
- The HMO management will also need to begin thinking about strategic issues and it is not too early to consider a board/management retreat to do some strategic planning.
- One key task in the finance area is the development of a “Sources and Uses of Funds” document which is the major financial forecasting and reporting vehicle.
- Some consideration and planning needs to be focused on the development of information that will be going to top management and the board. While it is early in the development of the HMO. Reports for HMO Institutions normally fall into the following classifications:
 - a. Board Level Reports (Total membership, Profit and Loss, Balance Sheet, and Cash Flow Statement)
 - b. Membership and Marketing Reports
 - c. Financial Management Reports (very detailed)
 - d. Health Service Reports

note: List is from (*HMO Critical Performance Measures for HMO Management and Board*, published by Birch and Davis)

There is a great deal to be completed as the above sections have outlined. While the management is enthusiastic and excited, it will be a difficult and long road to the successful implementation of the HMO in Shymkent.

VI. EVALUATION

In the context of this trip report the process of evaluation is fairly straight forward. As we are not attempting to evaluate the outcomes of the given programs, we need only monitor if the report and recommendations have been reviewed by the respective parties. Considering the difficulties due to translation in Russian from English, and the variety of differing priorities presently being experienced in the project, the consultant's recommendations are as follows:

1. Was the Trip Report submitted in a timely manner and within the guidelines of the original Zdrav Program standards? (5 days after completion of the trip)
2. Was the Trip Report, or the respective priority sections, translate into Russian for the counterparts to review in a timely manner? (one month from completion of trip)
3. Was the essential elements of the Trip Report reviewed with the respective Zdrav Reform personnel in a timely manner? (one week)
4. Were the recommendations implemented, or at least reviewed and decisions taken not to implement in a timely manner? (2-3 months from completion of trip)

While all of this is really monitoring, and not formal evaluation, it should suffice to meet the necessary criteria for evaluation processes within the project.

VI. ACTIVITIES

Outlined below are the respective activities, events, and persons met during the visit:

November 26/27: Travel to Almaty via Frankfurt.

November 28: Met with office staff in the morning to review plans and priorities, and met with Mr. Imanbaev Talapker, Head of the National Mandatory Health Insurance Fund to review issues related to organizational, board, and management of the recently established National Insurance Fund.

November 29: Met with Imanbaev Talapker, again to review information submitted the prior day and to review scope of work with respect to organization and management issues. Imanbaev stated that the new fund was to run more like a bank holding company than and insurance company. The fund was allowed 2.8% for administration or one employee per 10,000 population (this compares with 1/15,000 in Russia), which results in approximate total of 1700 employees, with 80-100 in the central fund and 30 in oblast funds. The fund will use the local savings bank as a core structure for the collection of funds. He is estimating \$500,000 for computer network costs, at 25,000 for each of 20 oblast funds. He had a number of questions with regard to organizational structure. Imanbaev state that approximately 40% of funds would come from employers (for employees) and 60% from the budget (the non-working), for a total funding of 26 Billion Tenge. The basis Mission of the fund would be 1) to provide each human being with

the right to a basic package of health care benefits, and 2) to reallocate funds between the different sectors of the country.

November 30: Morning was spend preparing materials and translations for the coming meeting with Imanbaev in the afternoon to review newly prepared materials. Met with Joseph Rittman, Health Care Reform Technical Assistance Project to review what we were doing with Imanbaev. Met with the staff of the NMHIF without Imanbaev, and discussed various issues centered around payment systems, computerization, quality assurance, and tied up organizational issues. Meeting with Imanbaev added further information about the preliminary planning of meeting with Oblast Directors on December 12, staffing by the 1-10th of January, February-March for contracting with employers, March to sign up providers, April-July to begin payment. It was clear he has ambitious overly optimistic plans.

December 1: Worked on a number of issues primarily the list of issues, problems, and recommendations for the National Mandatory Health Insurance Fund and the Shymkent HMO information and workplan in preparation for trip to Shymkent.

December 2/3: Worked with Sheila O'Dougherty on a number of issues from Karakol, reviewed and revise papers for NMHIF and the Shymkent HMO.

December 4: Delivered strategy paper to the NMHIF and met with key counterparts to review ideas, issues, problems and recommendations. Met with Sheila O'Dougherty and the systems computer personnel to review progress on the Karakol computer work, focus on priorities for the next trip on early 1996. Imanbaev further stated that the People Saving Bank had been selected as the main banking institution and network institution. He feels that pricing is the key issue and he will selectively contract with providers. Key items highlighted were 1) The Fund as a financial organization with revenues from employers, 2) Working population will pay only for employed 3) Risk adjusted pricing for specific industries 4) the budget will not pay for providers (ie beddays) but for programs (ie immunizations). The fund will do selective contracting and will force reduced capacity in this way. He further stated that the changes should be evolutionary and not revolutionary over a number of years. We agreed to put together a major paper reflecting our TA abilities and outlining our present thinking on a number of issues. Imanbaev highlighted a \$5 million loan from the World Bank, of which he would get some \$3.5 million for the Fund. He stated that he thought our step-down cost finding method too complicated for their use. He then dropped the bomb: stating that their would be two funding organizations, not one, and that the NMHIF would only handle the employer payment side and that another group would handle the budget funds. This would mean that there would be two tiers of care, and two benefit packages. All of this is in disagreement with the overall law and our original understandings. We shall see.

December 5-8: Worked on major papers for NMHIF outlining Payment Systems, Information Systems, Rationalization, Restructuring, and Quality Assurance issues, problems programs and recommendations.

December 9/10: Worked on a number of issues including NMHIF papers, Phosporus HMO activities and plans, and conference materials.

December 11-13: Worked on conference materials and issues including NMHIF and HMO.

December 14-16: Attend Conference and Workshops and presented materials on issues.

December 17-20: Travel to Shymkent and worked on HMO and Board/Management items.

December 21: Travel from Almaty to Philadelphia via Frankfurt and Washington

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B. LIST OF PERSONS CONTACTED

Almaty Office of Abt Associates:

Michael Borowitz
Rebecca Copeland
Sheila O'Dougherty

Almaty:

Imanbaev Talapker, Director General of the National Mandatory Health Fund (NMHIF)
Ramazanov Meurat, Deputy Director for Finance, NMHIF
Khamzaev Bakhyt, Deputy Director for Medical Affairs, NMHIF
Ibrashev Makhambet, Deputy Director for Administration, NMHIF
Kazymbetov Polat, Almaty Oblast Director of MHIF
Joseph Rittman, Health Care Reform Technical Assistance Project of World Bank

Shymkent:

Shymkent Office of Abt Associates

Rose Kane
Shel Hulac
Igor Samchenko

Shymkent HMO

Baidauletov L. P. - chief doctor

SKO-MHIF

Makasheva Lubov - Director of MHIF

C. ACRONYMS

BHIF	Basic Health Insurance Fund, also MHIF
BOD	Board of Directors
CEO	Chief Executive Officer
DG	Director General
HMO	Health Maintenance Organization
HSP	Hospital Strategic Plan
IB	Institution Building
MIS	Management Information System
MHIF	Mandatory Health Insurance Fund, also BHIF
NMHIF	National Mandatory Health Insurance Fund
OMHIF	Obast level Mandatory Health Insurance Fund
OD	Organizational Development
SKO-IDS	South Kazakhstan Oblast- Intensive Demonstration Site
SOW	Scope of Work
SP	Strategic Planning
TA	Technical Assistance
ZRP	ZadravReform Program

ANNEX A

CONSULTANT ORIGINAL SCOPE OF WORK TASK ORDER #238 ZDRAVREFORM

Name: George P. Purvis

Dates of Visit: November 26 through December 21, 1995

Areas of Expertise: Organizational Development of HMO Board of SKO

Work Site: Shymkent, South Kazakhstan Intensive Demonstration Site

Collaborating ZdravReform Team Members: Michael Borowitz

Tasks:

1. To prepare an initial and partial Fundholding System for Family Practitioners, including an outpatient fee schedule and capitation rate.
2. To work with Phosphorus Hospital on the development of a management systems and quality assurance
3. To develop a Board for the Hospital based HMO and assist with systems development,
4. To assist three Family Practitioners develop a business plan.

Outputs:

1. Recommendation on setting up an initial and partial Fundholding System for Family Practitioners, including a initial capitation rate and an outpatient fee schedule,
2. Recommendations on management systems development and quality assurance,
3. Development of a hospital based HMO Board for the Phosphorous Hospital and related management systems,
4. Formation of Business Plan for three Family Practitioners.

BACKGROUND OF THE CONSULTANT:

George P. Purvis is an international health and hospital management consultant who has worked in twenty countries in Europe, Asia, and Africa. Originally trained as an industrial engineer, with an MBA in Finance, he has spent his entire career working on the issues of revenue, cost and quality in health and medical institutions and with governments. He has held positions as Chief Financial Officer, Chief Operations Officer, and Chief Executive Officer for a number of domestic and international health care organizations, as well as being a consultant to physician offices, hospitals,

polyclinics, HMO's, PHC programs, developmental foundations, and Ministries of Health. He is a fellow of both the American College of Healthcare Executives (ACHE) and the Healthcare Financial Management Association (HFMA). He has conducted Organizational Development (OD) analysis and workshops on Board/Management relationships in a number of countries.

ANNEX B

Progress Report on the First Nine Months of The Development of an HMO for Shymkent, South Kazakhstan By: I. Baidaletov, Chief Doctor-Fosforous Hospital & Dr. Shel Hulac SKO- IDS Manager

The concept of exploring the possibility of establishing an HMO in Shymkent, South Kazakhstan was first discussed in March of this year over a lunch at the Kazakhstan Hotel in Almaty; between ZRP Almaty Manager of Health Data System - Sheila O'Dougherty, ZRP Bethesda - Dr. Jack Langenbruner and Shel Hulac, the Manager of the South Kazakhstan Oblast (SKO) Intensive Demonstration Site (IDS.). Dr. Langenbruner posed the following question, "The MHI - Fund development is somewhat delayed, family practice is not yet a hot topic, what program is there that ZRP could do in Shymkent?" The immediate reply was, "Let's consider developing several hospital-based HMO's. Such an approach would allow the health reform program in our oblast to capitalize on the strength of existing hospital management." After discussion all three agreed that this could be a positive development.

Several weeks later it was learned that the Dr Jim Rice the Director of the *ZdravReform* office in Moscow had organized a study tour of health maintenance organizations (HMO) in the United States. Moscow contacted the Central Asian Regional Director, Dr. Michael Borowitz and asked him to nominate two people from Central Asia to attend the study tour. He, in turn, contacted the SKO - IDS office with a request to obtain nominations for the two slots. The head of the local health reform effort, Madam Sailakul Barakhova, the Oblast Deputy Administrator for Social Programs selected two of the most senior chief doctors from Shymkent, the Chief of the Emergency Hospital and founder of its HyperBaric Medicine Center Dr. Orymbayev and the Chief of the Fosforous Medical center and Clinics, Dr. I. Baidaletov. They were then approved by the Almaty ZRP Office and by US/AID and they departed to the Minneapolis in the state of Minnesota in the U.S. They spent approximately three weeks on an intensive study of health maintenance organizations and their relevance to the Shymkent health care system redevelopment.

During the time these two Chief Doctors were in Minneapolis, Madam Barakhova herself, along with Galena Shim of the Oblast Economics Department were on a study tour arranged by the Vermont Insurance Institute and the ZRP Bethesda office. They had an in depth look at the health insurance industry in the U.S. Also, Dr. Marat Mouminov, the Director of the Oblast health department went on an extensive study tour of the pharmaceutical industry in the U.S. These five became the core group for a series of reforms which have occurred over the past six months. They were followed by the City of Shymkent Director of Health, Dr. ### Useynov and the Director of Shymkent Finance Department Ismail Askarov on a study tour of health finance at Boston University. In 1993/94 two other member of the health reform team, Dr. Andre Novikov and Dr. Igor Samchenko also had been to Boston University for the health finance course. In all, twelve senior health care decision makers have been involved in study tours to foreign locations during the past 30 months.

The first concrete step in the HMO development process was for Doctors Urembayev and Baidaoletov, upon their return from the United States, to decide to undertake the project of developing it. They approached the Shymkent Director of Health and the Deputy Mayor for Social programs and reviewed with them the importance of the HMO idea for the future of the Shymkent Health department. They were given a tentative approval to explore the idea further. Working with the SKO - IDS office it was decided to have several technical assistance and training efforts in Shymkent, to help prepare the ground for further developments. Early in August Dr. Roger Birnbaum and George Purvis conducted technical assistance work on HMO development and on strategic planning for health care facilities. Late in August a workshop for thirty staff of the three pilot hospitals was held on general accounting principles. Then in September a workshop was held on alternative payment systems lead by ZRPs Dr. Gary Gaumer assisted by Kevin Quinn. Dr. Lauren Jones and Dr. Hans Loken conducted a one week workshop on continuous quality development for thirty medical personnel. Late in September, ZRP Bethesda Dr. Alexander (Sasha) Telukov made his third technical assistance trip to Shymkent, this time to work on the details of development of a hospital based HMO.

At the Shymkent City government level intensive discussions were being held to determine the extent and nature of a possible HMO. Communications were established between the City and relevant Oblast government officials by Madam Barakhova's office. The Mayor of Shymkent subsequently issued a decree directing that the Fosforous Hospital and the Emergency hospital develop an HMO. This decree was later endorsed by the Oblast Chief Administrator. The Mandatory Health Insurance Fund staff initially saw the HMO development as a threat to their emerging role as the predominant funding source for health care in the oblast. After careful work by Dr. Telukov, the management of the MHI-Fund and the Oblast Director of Health Dr. Marat Mouminov agreed to support the idea of an HMO in Shymkent City, as long as it was not based at just one hospital. This contribution was later endorsed by the new Deputy Mayor for Social programs, Mr. Madeov and by Madam Barakhova and the Director of the City Health department Dr. Useynov. The new Deputy for health care to Madam Barakhova is Madam Coraleigh Mukhtarovna (the former Deputy Mayor for Social programs.) She has played an important role in cementing communications between the City and the Oblast on this important issue.

In the meantime it has been recognized that most funding for the HMO experiment will come through the MHI - Fund. The potential of the experiment has required progress on two fronts, both the MHI - Fund and the HMO. It is recognized, however, that the HMO provides an important provider alternative to that of the long established style of budget supported hospital based care. An initial attempt had been made to enroll all of the employees of a local enterprise in the HMO. This idea was, however, to much of a threat to the potential income stream of the MHI fund and was therefore scrapped. The MHI - Fund in South Kazakhstan has been under development for just over a year. A number of administrative systems been established. These include a modern computer network which was established through a grant arranged by the SKO - IDS office and ZRP Almaty through Mercy Corps.

This computer network has become the heart of an emerging data network which will support the management of the Fund in our oblast. Both the HMO and the Fund will be using data obtained as part of a mutual development program.

The legal basis for the HMO program to date includes extensive work by City and oblast legal departments. An all parties "Memorandum-of-Understanding" (MOU) covering the full development of the HMO and a parallel fund holding experiment for family practitioners was signed by the Oblast Akim and an officer of Abt & the ZRP Bethesda office late in November. Those approving the MOU include Madam Barakhova, the Mayor of Shymkent, the Director of the City Health Department, the Director of the Oblast health department, the Director of the Regional Office of the ZRP in Almaty Both US/AID Almaty and Washington also reviewed the MOU and provided no objections. Since the signing of the MOU there have been a number of documents drafted by Dr. Telukov and adapted locally by relevant officials.

This particular project has demonstrated a bottom-up approach to the development of an HMO for the City of Shymkent. It also has shown the value of an Intensive Demonstration Site as being best suited to the initiation and support of a locally developed experiment in healthcare delivery. The opponents to the HMO experiment are the same types of vested interests that one would encounter in Spain, Brazil, Singapore or the United States. The early experiments with HMOs in North America required several years to accomplish what has taken place in Shymkent in just five months. The current estimate is that the HMO will be ready for full operation early in April of 1996 and that it will provide services to 50,000 beneficiaries or at least 10,000 families, under a contract with the Oblast Department of the MHI - Fund. It is expected that the HMO will be replicated so that two or three additional HMOs will become available in Shymkent, providing a level of managed competition for the benefit of employers, employees and their families in this oblast. By the end of 1997 the results of this important experiment should become known.

Many technical details remain to be handled. As the coalition sponsoring this experiment grows and strengthens, the possibilities for failure recede. It must be clear that the Shymkent HMO now is proceeding under its own steam. In the future it will require less and less assistance from the *ZdravReform* program. Several more study tours to look at specific skill areas (especially actuarial science and contract preparation) will be helpful. We would like to report that all of this development has been part of a grand plan, envisioned from the start. In fact, the development of the HMO has been 20 % inspiration, 30% luck, 25% opportunity and 25% very hard work, but isn't this true of all great projects. Nothing ever unfolds exactly as we originally planned. The final product or result is often just such a combination of factors, which results in something which is most suited to the local situation.

The direct costs for the Shymkent HMO experiment to date are around \$150,000 to the *ZdravReform* program and approximately the same combined amount for City and Oblast governments. It is estimated that by the time the HMO becomes operational the total combined costs will not exceed \$400,000. The return on this investment, in the first two years of operation of the HMO should exceed \$800,000 of savings to all levels of government and to the MHI - Fund. Future savings after 1997 will be immense. The details of this benefit/cost business analysis are being completed and should be available in published form early in February of 1996.

As the full impact of improved quality, improved access, improved efficiency and reduced cost become clear to decision makers and to consumers and enterprises, then the reality of sustainable

success will be realized in South Kazakhstan Oblast. The appendix lists the various documents which have been prepared during the course of this experiment. The actual text of these documents will become available as a joint ZRP/Bethesda, ZRP/Almaty, SKO - IDS and Oblast & City Government published report during the second quarter of 1996.