ZdravReform/ЗдравРеформ

Uzbekistan Health Reform Overview

October 1999

Submitted by the Zdrav*Reform* Program to:
USAID/CAR

Funded by:
AID Contract No. CCN-C-00-94-00023
Managed by Abt Associates Inc.
Almaty, Kazakhstan

Uzbekistan Health Reform Overview

Introduction

In Uzbekistan, USAID/ZdravReform support for the introduction of a comprehensive health reform model began in 1997, as part of the development of the World Bank health sector loan. Unlike in Kazakhstan and Kyrgyzstan, where experience from existing USAID/ZdravReform demonstration sites was used as the basis for World Bank health sector projects, the USAID/ZdravReform Program began its activities in Uzbekistan simultaneously with the World Bank. This strategy came about because of the initial reluctance on the part of the government of Uzbekistan to embark on a comprehensive health reform program. The possibility to finance the capital investment necessary to introduce the Government's new rural primary care program, however, created an opening for a more comprehensive health reform program.

Using the World Bank loan as an impetus to initiate health reforms has had mixed results. On the positive side, the loan created the opportunity and incentive to break through previous political barriers to reforms. Without this catalyst, there would have been little opportunity for reforms, particularly in financing and management. On the negative side, however, because comprehensive health reform was a condition to get the capital investment that the government wanted, it is unclear how much political buy-in actually exists for some aspects of the reform program.

In Kazakhstan and Kyrgyzstan, health reform itself was identified as a goal by the governments well before the opportunity for material investment through a World Bank loan was made available. The government of Uzbekistan, however, agreed to comprehensive reforms, which they had previously rejected, as part of a compromise with the World Bank. The oblast level reform demonstrations, therefore, were initiated largely through top-down planning and national decrees, which did not allow the foundation for reforms or political will to be built gradually in the oblasts. Building this foundation includes several steps that are considered to be vital for the ultimate success and sustainability of the reforms, including creating an understanding of the goals of the reforms among a wide variety of stakeholders, developing human resource capacity to implement the reforms, and setting up health management information systems.

The World Bank procedures themselves have also affected the natural process and timing of reforms, which has been another difficulty of starting the USAID/ZdravReform demonstration simultaneously with the World Bank. Most importantly, because of some inflexibility in World Bank administrative procedures, the pace of reforms is dictated partially by World Bank procurement schedules. This has also interfered with the ability to gradually build foundations at the oblast level and let the reforms progress naturally as local capacity is increased and the understanding of the reforms deepens. Furthermore, the timing of procurements through the World Bank project has created pressure to roll out to

other oblasts before the Ferghana demonstration has had the opportunity to mature and generate sufficient experience and lessons to guide the roll-out.

In spite of these issues, there has been significant progress in the health reform program in Uzbekistan. Although the depth of the commitment to the financing reforms can be questioned, there is clearly political will for the development of a strong system of rural primary care, and for giving the primary care sector increasing independence from Central Rayon Hospitals. The commitment to strengthening primary care has been demonstrated in Ferghana Oblast by the restructuring of the entire primary care system in the experimental rayons, and increasing the per capita share of oblast health resources allocated to primary care in the experimental rayons from 11 percent in 1998 to 20 percent in 1999.

In addition, while arguing for a more gradual pace and a greater focus on foundation-building, the USAID/ZdravReform Program has also altered some of its implementation strategies to adapt to the different circumstances of the World Bank collaboration in Uzbekistan. For example, in an effort to encourage bottom-up participation in the reforms, the Program has focused more intensively on community involvement, particularly through the small grants program, independently of the World Bank project. As a competitive advantage of the USAID/ZdravReform Program is its flexibility, it has been able to complement the World Bank's clinical strengthening activities with more immediate, targeted assistance. For example, while the World Bank long-term clinical training was delayed, the USAID/ZdravReform Program initiated short-term clinical training modules for primary care physicians in the experimental rayons of Ferghana Oblast.

The health reform program in Uzbekistan should focus on continuing to build and strengthen the foundation for reforms through the partnership between USAID and the World Bank, and expanding the reforms as the foundation is built. The foundation relies on increasing awareness about reforms among policymakers, health professionals, and the population; training, both clinical training and in areas such as financing, management and computers; and establishing health management information systems. Experience from other health reform sites in Central Asia shows that as these foundations are put in place and small steps are achieved, the commitment to reforms grows, and the next steps are more likely to be driven by demand from the local level.

History

For context, it is important to understand the lengthy process that led to the eventual project that is currently operational in Ferghana Oblast. Under the USAID/ZdravReform contract, it was envisaged that intensive health reform demonstration sites would be developed in Kazakhstan, Kyrgyzstan, and Uzbekistan. In Kyrgyzstan and Kazakhstan, USAID/ZdravReform developed demonstration projects at the beginning of the project in 1994 and these mature demonstrations were then rolled out to other geographic areas through World Bank projects. The Government of Uzbekistan, however, initially expressed no interest in working on health reform.

Almost simultaneously, beginning in 1993, the World Bank was attempting to develop a health sector loan for Uzbekistan that included health reform. The Government of Uzbekistan was interested in receiving World Bank support only for the domestic production of pharmaceuticals. Despite numerous World Bank missions to Uzbekistan from 1993-1996 to design a health sector loan that could be supported by technical assistance from USAID/ZdravReform, no common strategy could be agreed upon.

In 1996, the Government approved a new program to strengthen the rural infrastructure, which included a plan to build new health facilities in rural areas known as rural physician posts (the Russian acronym is SVP). The Government asked the World Bank for funding to support this program. The World Bank agreed to support this process if a health reform component was included in the project, focusing on financing and management reforms that would lead to a sustainable health care system. The Government insisted that domestic production of pharmaceuticals be included in the project. The World Bank agreed only to carrying out a feasibility study for the domestic production of vaccines.

Project preparation continued with the support of Abt Associates Inc., whose technical assistance was procured to design the World Bank loan. The design of the project was a complex process of negotiations to fulfill the objectives of both the Government and the World Bank. In the end, the domestic production of vaccines was not included in the project financing. The World Bank recommended that production should be developed as a private, commercial venture. The government agreed that financing reforms might be needed, but requested that they be tested as an experiment rolled out by the World Bank loan only once they were proven successful.

It was agreed that three experimental rayons in three pilot oblasts would carry out an experiment in health financing reforms, and after two years these pilots would be evaluated to determine which model should be adopted. In 1997 as part of the design process, the Government of Uzbekistan and the World Bank requested USAID assistance to support the financing and management experiments, which would form the basis of the World Bank loan. USAID agreed to begin the experiments in Ferghana oblast as the lead oblast, and also agreed that the reforms would begin before the World Bank loan was finalized and funds began to flow. USAID/ZdravReform opened an office in early 1998 to begin implementing the financing experiments in Ferghana oblast.

The World Bank-Financed "Health" Project

The World Bank-financed "Health" project supports a comprehensive program for strengthening rural health care in three oblasts: Ferghana, Navoiy, and Syr Darya. The project became effective in May 1999.

The loan consists of three components:
1) strengthening primary care which consists of material equipment for rural health facilities;
2) support for a broad reform of the medical education system to support the development of family medicine; and

3) financing and management reforms to improve the overall efficiency of the health sector.

USAID agreed with the Government of Uzbekistan and the World Bank that it would use the USAID/ZdravReform experience in Kazakhstan and Kyrgyzstan to develop a comprehensive model of rural health reform in Ferghana oblast. USAID/ZdravReform agreed to pilot test the reform model in three experimental rayons in Ferghana oblast. Lessons learned from the pilot test would then be used to roll out the reforms to the rest of Ferghana oblast and to Navoiy and Syr Darya oblasts over the course of the World Bank loan.

The basic model of the reforms is similar to the reforms that have been implemented in Kazakhstan and Kyrgyzstan by USAID/ZdravReform but adapted to the Uzbekistan context and the rural setting. This model includes:

- Establishing a legal basis for reforms
- Restructuring the delivery system for primary care
- Strengthening the clinical capacity of primary care
- Introducing new payment systems for rural primary care facilities based on capitation, as well as new management mechanisms to support new payment systems
- Developing computerized information systems
- Involving the population in health reform efforts
- Monitoring and evaluating the reform process

Program Results

Based on this health reform model, USAID/ZdravReform has supported the Government of Uzbekistan and the World Bank-financed "Health" Project to achieve progress in a very short time. For instance, USAID/ZdravReform has been instrumental in providing technical assistance to establish a national and oblast level legal framework for rural health care reform, design and implement new provider payment systems based on a capitated rate, and include all primary health care facilities in the three experimental rayons in Ferghana Oblast in the new payment systems. Additional results by topic are described briefly below.

A. Establishing Legal Basis for Reforms

Over the past several months, a series of national and oblast-level legal documents were ratified that support the implementation of Postonovleniye #100. Postonovleniye #100 governs the implementation of the World Bank-financed "Health" Project. Together these documents provide the legal basis to:

- Form a network of juridically independent primary care institutions in three experimental rayons of Ferghana Oblast (Beshariq, Quva, and Yazyavan);

- Increase the proportion of oblast health care funds allocated to primary care;

- Pool primary care funds for the three experimental rayons in Ferghana Oblast at the level of the Oblast Health Department;

- Finance all independent juridical primary care entities in the three experimental rayons in Ferghana Oblast according to a single per capita rate;

- Add the position of financial manager to the SVP and SVA/FAP complex staff schedule.

B. Restructuring the Delivery System for Primary Care

Health reform efforts in Ferghana Oblast have been successful in establishing a network of juridically independent primary care clinics. Each clinic has its own bank account and receives financing directly from the Oblast Health Department on a per capita basis. USAID/ZdravReform has begun providing technical assistance to strengthen the clinical capacity of the facilities through clinical training and equipment so that the invigorated primary care system is able to provide a wider range of integrated, high quality services to the population. This new primary care network will be able to meet a higher proportion of the health care needs of the population, thereby reducing excess referrals to hospitals and polyclinics and increasing the cost-effectiveness and quality of the entire health care system.

During the restructuring process, USAID/ZdravReform was successful in convincing key policymakers to include all primary care facilities, not only the 12 SVPs formed by the World Bank-financed "Health" Project, in the reform program. Therefore, all SVAs and FAPs in the three experimental rayons of Ferghana Oblast were administratively consolidated and their catchment areas joined to form 33 SVA/FAP complexes, which were then registered as independent juridical entities. The primary care network in three rayons in Ferghana Oblast now includes 45 facilities.

Expanding the reforms to include the entire primary care sector was seen as a crucial step, because SVPs currently make up approximately one-third of the rural primary care delivery system in the three oblasts included in the World Bank-financed "Health" Project. Reforms that are targeted to less than one-third of the primary health care sector can have only marginal effects on the overall performance of the health care system and the health status of the population. It also creates an uneven primary health care sector, where the quality of care a patient receives depends largely on geography, that is whether he/she lives near a newly constructed and equipped SVP or near a SVA. Under this model, primary health care services become extremely inequitable within a rayon. Moreover, the current distinction between SVPs and SVA is largely artificial, because over time all SVAs will be converted into SVPs. It therefore makes sense to begin strengthening SVAs as soon as possible, so the gap between the clinical capabilities SVPs and SVAs does not widen, and so that SVAs can be converted into SVPs more rapidly.

C. Strengthening the Clinical Capacity of Primary Care

USAID/ZdravReform and the World Bank-financed "Health" Project have been working together to strengthen the clinical capacity of the new network of primary care facilities through the provision of clinical training and equipment.

The World Bank-financed "Health" Project is currently collaborating with the British Know How Fund to reform the medical education system and to, ultimately, create two new cadres of health professionals, family medicine specialists and universal nurses. In the interim, USAID/ZdravReform is providing a series of modular short-term courses aimed at rapidly improving the clinical skills of doctors and mid-level health personnel. The courses were designed to target the leading causes of morbidity and mortality in Ferghana Oblast. Seven courses have already been developed and many physicians and nurses trained. These courses have also been approved by the Tashkent Institute for Advanced Medical Education (TashIAME). Health personnel who complete the courses will receive a joint certificate from TashIAME and USAID/ZdravReform. The modular system could be expanded to create a system of retraining existing physicians into family physicians, which could function in parallel with the longer-term re-training of medical personnel.

In total, 70 physicians and nurses were trained in reproductive health and family planning, 62 in rational breastfeeding, 61 in diagnosis and treatment of cardio-vascular diseases and arterial hypertension, 71 in emergency medicine and first aid, 72 in treatment of diarrhea, 75 in treatment of acute respiratory infections, and 53 in rational prescription of drugs. USAID/ZdravReform is evaluating retention of knowledge and use of skills learned by doctors who participated in the short-term clinical training. Additional courses on prevention and treatment of anemia and goiter will be introduced this fall.

In addition, the World Bank-financed "Health" Project has initiated the procurement of medical equipment for the 12 SVPs in Ferghana Oblast. However, the entire system of primary care is in transition and still consists of SVA/FAP complexes as well as SVPs. In the three experimental rayons of Ferghana Oblast, less than 30 percent of the primary care facilities are SVPs. Therefore, USAID/ZdravReform has begun the process of procuring limited equipment to SVA/FAP complexes until the World Bank project can be restructured to finance the clinical strengthening of all facilities in the primary care sector in the three experimental rayons, including SVA/FAP complexes.

D. Implementing Finance and Management Strengthening Reforms

A new per capita payment system has been implemented for the SVPs and SVA/FAP complexes in the three experimental rayons of Ferghana Oblast since mid-1999. In addition, a new management system is being implemented in the primary care facilities, including the addition of the new position of financial manager to the staff schedule for primary care facilities. The new financing and management systems have the dual goals of increasing the resources allocated to primary care, while at the same time providing incentives to use those resources more efficiently. The implementation of the financing and

management reforms has been supported by intensive technical assistance from USAID/ZdravReform.

1. New Payment System

The development of the first phase of the per capita payment system began in mid-1998, with implementation initiated on April 1, 1999. The pool of funds available for primary care in the three experimental rayons was determined based on the calculation specified in Postonovleniye #100. The primary care per capita rate in the experimental rayons was increased from 11 percent to 20 percent of the overall per capita availability of health care funds in the oblast.

Primary care funds for the three experimental rayons were pooled at the Oblast Health Department. This was an important step, because it allowed a single capitated rate to be paid to all primary care facilities in the three rayons, thereby improving equity. To calculate the capitated rate, the primary care pool of funds was divided by the total number of people in the catchment areas of the 45 SVPs and SVA/FAP complexes, and budgets were developed for each SVP and SVA/FAP based on the per capita rate multiplied by the population of the catchment area.

Business plans were developed by financial managers and heads of experimental facilities to determine the allocation of capitated budgets across budget chapters. Previously, the allocation of budgets across chapters was determined by the financing institutions rather than the health facilities themselves. The facilities are currently receiving their financing according to the chapter budgets in their business plans for April-December 1999. They will have only limited flexibility to reallocate expenditures across budget chapters until permission is granted by the Ministry of Finance for chapterless financing. A decree was recently signed by the Ministry of Finance on chapterless financing of all budget institutions in the republic. Depending on the interpretation of the decree and supporting regulations that are enacted in the health sector, this may provide the basis for greater financial autonomy for primary care facilities next year.

In the next phase of the primary care per capita payment system, which is planned to begin in January 2000, the per capita rate will be increased to correspond to the expansion of the scope of services provided by SVPs and SVA/FAP complexes, and the per capita rate will be adjusted for the age and sex composition of the catchment areas. A survey of more than 25,000 primary care encounters was conducted with USAID/ZdravReform assistance to calculate the primary care age/sex adjustment coefficients to be applied beginning in 2000.

2. New Management Systems

USAID/ZdravReform has been successful in developing new management mechanisms to support the new provider payment systems. The introduction of the new management systems began with the development of a new staff position, the financial manager, in primary care facilities. At the end of 1998, 30 financial managers were hired on a competitive basis and trained in a 3-month course on accounting, business planning,

marketing, and medical statistics provided with USAID/ZdravReform assistance. Sixteen trainees passed the evaluation process that followed the training and received certificates giving them the right to work as financial managers. The financial managers began working in SVPs and SVA/FAP complexes as employees of the Oblast Health Department as of April 1, 1999.

The financial managers were assigned to serve multiple SVPs and SVA/FAP complexes, based on the size of the catchment population served. The USAID/ZdravReform Program donated 16 bicycles to facilitate the travel of financial managers between the primary care facilities.

As their first task, financial managers worked with head doctors of SVPs and SVA/FAP complexes to develop business plans and chapter budgets for the remainder of 1999. Unfortunately, since then financial managers spend much of their time preparing multiple financial reports and obtaining necessary signatures for the receipt and expenditure of funds by the primary care facilities. USAID/ZdravReform is working with the Oblast Health Department to expand the role of financial managers as part of a management team together with primary care head physicians. USAID/ZdravReform conducted a survey of financial managers to determine the most significant barriers to expanding the scope of their work. It was found that the financial managers feel that they would be able to play a larger role in health facility management if they served only one primary care facility, if the financial procedures were streamlined, and if the managers had better skills and more training.

The USAID/ZdravReform Program has been focusing much of its effort on developing an appropriate and sustainable training program for financial managers. Needs for follow-up training for financial managers are continually being assessed by the Ferghana Oblast Health Department and USAID/ZdravReform, and short courses are provided as needed. In addition, four U.S. Peace Corps health management volunteers were assigned to work with the Oblast Health Department in the three experimental rayons to provide ongoing support for training new financial managers. USAID/ZdravReform currently is designing a rotating cycle of training modules for continuous training of future financial managers, and is developing a procedures manual for SVPs and SVA/FAP complexes.

E. Developing Computerized Information Systems

Simultaneously with the development of the new provider payment system, USAID/ZdravReform began to develop a new computerized health information system for Uzbekistan based on the information system being used by the Kyrgyzstan health reform program. Two databases comprise the information system: a population database and a clinical and financial information database.

1. Population Database

To maintain information on the catchment area of each primary care facility, a population database is being established that contains information on the demographic structure of the

catchment area of each SVP and SVA/FAP complex in the experimental and control rayons of Ferghana Oblast. Basic individual and family demographic information was collected for all of the catchment areas of the 45 primary care facilities in the three experimental rayons, and for the catchment areas of 38 facilities in the control rayons, covering more than 800,000 people in all. The population database will also track births, deaths and migrations, which is important information both for the implementation of a per capita payment system, and for monitoring the effects of the reform program on individual health service utilization and health status.

2. Clinical and Financial Information System

The clinical and financial information system will provide information to the Oblast Health Department and the primary care facilities on clinical utilization (visits, referrals, diagnoses) and revenue, cost, and expense data. Clinical heads and financial managers will be trained to use this data for decision making regarding resource allocation within their facility. In the past several months, USAID/ZdravReform and the World Bank Project Implementation Bureau developed new clinical and financial information forms for the new information system, established procedures for completing the forms, and defined the flow of information. Forms will be introduced into the facilities in early 2000.

F. Involving the Population in Health Reform Efforts

USAID/ZdravReform initiated health promotion and marketing activities aimed at involving the population in the health reform. Activities include: (1) creating and strengthening the role of non-governmental organizations (NGOs) in community health through a small grants program; and (2) implementing broad health promotion and marketing activities, including the promotion of healthy lifestyles.

1. Small Grants Program to NGOs

The NGO grants program was designed to help address health problems specific to rural populations in Ferghana Oblast, to strengthen the links between the population and health care facilities, and to strengthen rural civil society. USAID/ZdravReform provided technical assistance to NGOs, primary care facility doctors, and community-based organizations like mahallas by:

- Conducting research on mahallas and other local governing bodies and their link to the health sector and making recommendations on expanding these links to more effectively involve local governing bodies in the health reform process as well as in health promotion activities.

- Facilitating Participatory Rural Appraisal (PRA) field research to evaluate community health needs, resulting in many mahallas and communities expressing their need for clean drinking water as the most effective way to improve public health. (A recent USAID mission focusing on infectious diseases in Central Asia also identified clean and safe drinking water as vital first step in improving health outcomes in Uzbekistan.)

- Training interested mahalla representatives and primary care facility doctors in PRA techniques so that they could use these unique methods to identify their own health needs.

- Providing technical assistance in writing grant applications and designing projects that respond to community health needs.

- Advising interested community members on how to form and register an NGO.

After wide distribution of a request for applications, eleven applications were received for the first round of grants, focusing on clean water projects and improving reproductive health. Based on a competitive selection process by a committee using pre-set criteria, all eleven applications will be funded. A second round of grants will be selected and awarded in late October.

2. Health Marketing

USAID/ZdravReform recently developed a health marketing plan for Uzbekistan, based on the USAID/ZdravReform regional health marketing strategy. The plan includes activities to disseminate information about health reform to policymakers, health personnel, and the population. It also includes health promotion activities designed to increase the patient's responsibility for his own health and to advocate the use of family-centered, low-cost primary care facilities. Health marketing activities will be developed and implemented in close partnership with mahallas and the SVP Physicians Association. USAID/ZdravReform also will collaborate with the Peace Corps Volunteers working in primary care facilities as "Health Extentionists," USAID-funded Commercial Market Strategies (CMS) Project on social marketing in reproductive health, and the new TACIS-funded project on "Strengthening Preventive Health Care Policies and Programs" that focuses on promotion of healthy lifestyles.

G. Monitoring and Evaluation of Health Reforms

A health reform monitoring and evaluation strategy is being developed jointly with the Government of Uzbekistan, the World Bank, and USAID/ZdravReform. The strategy is based on the stated goals and objectives of the reform program, and a conceptual framework that demonstrates how the new policies are expected to lead to the desired outcomes. The World Bank-financed "Health" Project was designed with experimental and control rayons, so that evaluation could be made both across points in time and across matched "case-control" sets of rayons. The monitoring and evaluation strategy draws on existing administrative information sources, the new health management information system that is being introduced, and periodic surveys that provide more comprehensive information across points in time in the reform process.

Because the USAID/ZdravReform Program began working at the earliest stages of reforms in Uzbekistan, it was possible to establish some baseline information. This baseline

information includes a series of 18 focus groups with the population and health care workers to determine initial attitudes towards primary care, and a survey of more than 25,000 primary care encounters to compile a snapshot of initial primary care service delivery and utilization patterns in SVA/FAP complexes and SVPs. A health facility survey is currently being conducted to provide baseline information on the organization and management of the primary care facilities, the material resources of the facilities, and basic knowledge among health care workers about some key treatment protocols.

The next step in the evaluation process will be a household survey conducted at the end of 1999. This survey will be an important source of information to evaluate the impact of health reforms on many of the dimensions of the health and well-being of the population, such as the level of underlying chronic illness and out-of-pocket payments, that are not captured by administrative data.

Future work in this area will focus on institutionalizing the monitoring and evaluation process, and building capacity within the Ministry of Health and among oblast policymakers to carry out formative health policy evaluation.

Next Steps

Beyond the life of the current USAID/ZdravReform Project, several options exist for expanding and deepening reform efforts in Uzbekistan. These options fall into three main categories: 1) enhancing and strengthening the existing pilot project in the three experimental rayons in Ferghana oblast; 2) rolling out reforms to the rest of Ferghana oblast, and to Navoiy and Syr Darya oblasts; and 3) other potential activities that may be combined with any of the options above.

A. Enhance and Strengthen the Pilot in Ferghana Oblast

The first option involves continuation of the health reform experiment in three rayons in Ferghana oblast. Reforms are not yet mature and many more steps could be taken to enhance and strengthen the pilot. The financing reforms and information systems have largely just been introduced and the primary care facilities still are learning how to operate given their new autonomy.

Activities in these pilot rayons should include continued clinical strengthening and, after another year, expansion of the scope of services provided by the primary care facility. This will require re-thinking the World Bank design for clinical training which is based on a one-year retraining course in the medical institutes. Additional training is needed for all health personnel including nurses and laboratory workers.

The provider payment system should be further refined and a modified fundholding system should be introduced, where primary care facilities are required to “pay” for specialty and curative care from their capitated rate payment thereby discouraging unnecessary referrals.

A systematic evaluation of the pilot projects should be carried out in order to measure effects through the new information systems. These systems should show increased utilization and decreases in referrals to polyclinics and hospitals. The evaluation should be complemented by a repeat of the household survey (to be conducted in Fall 1999) in order to capture information on households and those who do not utilize health services.

B. Roll-Out the Reforms to the Rest of Ferghana Oblast and/or to Experimental Rayons in Navoiy and Syr Darya Oblasts

Under this option, USAID/ZdravReform would roll out health reforms to the thirteen remaining rayons in Ferghana oblast and/or to the six experimental rayons in Navoiy and Syr Darya. The World Bank has begun to lay the foundation for health reforms in Nayoiy and Syr Darya, and has requested technical assistance from USAID in setting up new primary care financing and management systems and re-training health personnel similar to activities currently being implemented in Ferghana. The health reform model would be modified based on lessons learned in Ferghana as well as conditions in Navoiy and Syr Darya, but activities would essentially resemble those described above, including:

- Establishing a legal basis for reforms
- Restructuring the delivery system for primary care
- Strengthening the clinical capacity of primary care
- Introducing new payment systems for rural primary care facilities based on capitation as well as new new management mechanisms to support new payment systems
- Developing computerized information systems
- Involving the population in health reform efforts

Synergies could also be created between other USAID and U.S. government-funded activities in Navoiy, including a five-year child survival and tuberculosis project being implemented by Project Hope and Peace Corps health extensionists that may be posted in SVPs in Navoiy.

C. Other Potential Activities

Additional activities could be introduced to complement and expand current and roll-out activities. These activities might include any combination of the following.

1. Begin implementation of an urban primary care reform model – This would include the creation of urban physician posts modeled on experience in Kazakhstan and Kyrgyzstan and would include renovation and equipment, and technical assistance for financing and management reforms. Since this is not included in the World Bank project, it would require capital funding for equipment and renovation. The likely sites would be: the rayon centers in the three experimental rayons and the oblast center. The urban model also could be developed in other cities in Ferghana oblast such as Margilan and Kokand.

2. Rationalization of the hospital system – This would include support for the development of the rationalization plan. Experience has suggested that administrative rationalization, by itself, will not be successful. Therefore, a new hospital payment system, a case-based payment system, needs to be introduced that is similar to the systems developed in Kazakhstan and Kyrgyzstan. The hardware for the computer information system will be provided by the World Bank. However, there would need to be limited capital investment to include some computers. The introduction of a new hospital payment system would also require significant technical inputs for management training in hospitals. Making the system work also would require capital investment to merge hospitals. For example, funds for combining hospitals.

3. Provide support to policy dialogue at the national level on key issues, including the design and introduction of a health insurance system.

4. Increase population and grassroots-level community involvement in the health sector by expanding the NGO grants program and by increasing health promotion activities in Uzbekistan linked to SVPs.

5. Integrate vertical programs into SVPs – This would include integrating infectious disease vertical programs and perhaps developing a pilot project on directly observed therapy short course (DOTS) linked to the experimental rayons. Similar activities could occur with sexually transmitted infections (STIs). Other vertical systems could be included in the process including psychiatry, oncology, and emergency care.

6. Provide support for the family medicine training center in Andijan. There should also be an alternative pathway for family medicine specialists to become accredited. Support should also be provided to train primary care nurses using the WHO LEMON course for nurses.

7. Develop drug formularies for all facilities to change the demand for drugs. This should be complemented by rational prescribing. However, the most critical issue is financing for outpatient drugs, which should be included in the payment systems. This will require some work on the development of drug reimbursement systems, improving distribution systems, and some national policy dialogue by access to hard currency accounts.

8. Support an experiment on Safe Motherhood using WHO treatment protocols in Ferghana. This would then be linked primary care activities.

9. Support an experiment on new options for increasing management autonomy in primary care, including private ownership of primary health care facilities.