(1) Standard Medical Services Model

1) Comprehensive rural medical services system at Oblast level will be designed with having the CRH and Oblast General Hospital take leading roles. This will conform to the recent decentralization policy, and improve accessibility to the medical facilities for the people in rural areas.

2) Capability of CRH and Oblast General Hospital facilities will be extended to more effective functioning through establishing above mentioned system.

3) At Rayon level, SVP, as first access point for out-patients, will be strengthened in their functions, whereby medical services at PHC level will be reinforced. Likewise, comprehensive mechanism for CRH, as first access point for inpatients, will be established, encompassing the system of medical treatments, patient referral system, emergency medicine, medical information system, preventive medicine, drug management, operation and maintenance system, financial management. Within the CRH, which is central to the medical services of Rayon, systems to provide medical information and to supply drugs for SVP will be established in collaborative manner, whereby coordination and supervision between the CRH and SVP will be realized.

4) At oblast level, it is practically difficult to transfer the patients from Oblast to Tashkent city. Thus, more efficient medical services system at Oblast level will be established with the Oblast General Hospital playing a central role. This requires consolidation and centralization of general out-patient treatment, in-patient treatment, laboratory tests and diagnostic/functional examinations, specialized medical services and emergency medical services, thereby medical services and cost will be best utilized.

5) For the achievement of the qualified medical services and appropriate management for financing and administration, the training and education for the human resources fostering will be implemented, standards and guidelines for the effective activities will be established.

6) For the implementation of effective and qualified medical services, improvement will be made for the conditions of facilities, equipment and drugs stocks in the

medical facilities. In addition, system and capability of laboratory tests and diagnostic/functional examination, drug management, and operation and maintenance of facility and equipment will be strengthened.

7) The appropriate blood transfusion system, which is to be based on non-familial, voluntary blood donations and a centralized blood testing facility in one or a few Oblasts, will be in place as a solution to improve (alleviate) the unbalance in demand and supply of blood at Oblast levels, and will secure the safety of blood supplied.

8) A central laboratory testing system will be introduced; the Oblast General Hospital will be the core of the centralized system, whereby capability of laboratory and sample transportation system will be strengthened. Consequently, quality control of the test results and accuracy of data will be improved, and the cost for testing will be reduced. A centralized system for diagnostic/functional examinations in Oblast levels also should be introduced at the same time of consolidation of many specialized hospitals into one well functional hospital.

9) The programs attempt to introduce a system for the efficient management and operation for health financing and budget at the Oblast and Rayon level. Also, the medical insurance system for universal coverage will be introduced. Therefore, establishment of organization for insurance and fostering the financing personnel are important.

10) The data and information from existing health information system are aggregated and it is difficult to identify and analyze the detailed situation of Rayon and medical facility level. Therefore, the data processing equipment will be provided to the Rayon level. As a result, the medical data collection and data communication time will be shortened; the information and data will be used more timely. The capability of medical administration and the policy planning by utilizing the health information will be enhanced.

(2) City Type Medical Services Model

1) City type PHC model for the first access point of the out-patients will be established. Moreover, GVP (city physician's point), PHC facility in city will be established with the system of medical treatments and patient referral system built in. The World

Bank proposed the same concept in the Health II Project, therefore it is important to collaborate with international organizations for achieving the qualified PHC services a city level.

2) At CCH (Central City Hospital), first access point for in-patients, extensive system will be in place, consisting of the system of medical treatments, patient referral system and medical information system, drug management, operation and maintenance system, financial management.

3) For more effective and better qualified medical services, it is necessary to improve the conditions of facilities, equipment and drugs stocks in the medical facilities. In addition, capability of drug management will be extended, operation and maintenance of facility and equipment strengthened.

4) The training and fostering of the human resources will be implemented for achieving better qualified medical services and more appropriate management for financing and administration. Also, standards and guidelines will be established to encourage efficiency in accomplishing tasks.

5) The Ministry of Health puts no control over private clinics, hospitals, and drug stores at city level. Therefore, to secure the qualified medical services, standards and guidelines are necessary. Also, government capability of monitoring and supervising the private sectors will be strengthened.

6) The emergency medical services system in city areas, especially in Tashkent will be further strengthened. Tashkent City already holds large size of population (10% of the country), and with the population of Tashkent Oblast combined, it accounts to more than 20% population of the whole country. Thus, it is important to establish emergency medical services that are prompt and efficient.

7) Specialized medical institutes at top referral are located in the big cities. The main tasks of these institutes as top referral facilities are to implement high level specialized medical services to the entire population of Uzbekistan population, to educate and foster the specialized doctors and research activities. Therefore, to serve these purposes, the capability and activities of the specialized institutes will be

enhanced.

(3) Medical Services Model for Remote Areas

1) Main concept for the development of the rural medical services is practically same as the standard model. The effective rural medical services system will be designed through the establishment of the self-contained medical services system within the Oblast. Therefore, the function and capability of CRH and Oblast General Hospital facilities will be enhanced.

2) In addition, the medical services for the remote area will include the following:
   - For remote areas, PHC model as a first access point for the out-patients will be established, and SVP plays a central role. Moreover, the system of qualified and effective medical treatments will be established.
   - The effective patient referral system will be established with provision of communication instrument and transportation vehicles.
   - As the Health II Project by World Bank presents similar concept, it is important to collaborate with international organizations in achieving the PHC services system in the remote areas.
   - In case of areas extremely remote, medical services at FAP under the control of the CRH and SVP will be provided and strengthened.
   - Medical activities such as home visit and pediatric health examination for the communities in. the remote areas will be promoted from the stand point of preventive medicine.

3) By the provision of legislative bases, priority distribution of medical resources will be arranged for the remote areas, because the existing health budget allocation system based strictly on per capita is inhibiting the implementation of adequate medical services. Budget allocation should take into account that regardless of the size of medical facilities, minimum fixed cost is unavoidable. In addition, the governments (state and rural) have to appoint the medical personnel to the remote areas.

4) Specifically in remote areas, a system of drug supply based on community's participation and initiative will be recommended; Mahalla drug stores and/or revolving fund for purchasing drugs.

5) Different approach from the standard medical services model should take, as consideration needs to be given on the patients' accessibility (time and the distance) to the medical facilities. As key-stations, the branch and/or liaison facilities of SVP or CRH will be provided in the remote areas. Likewise, laboratory tests and blood transfusion system will also follow the same flow of system.

15.8.3 Concept of the Stage -wise Improvement Programs

M/P will present the stage -wise improvement programs for effective implementation of the health care reform. At the initial stage, specific study areas will be selected for implementing the pilot project. The pilot study project will be carried out and examined on how designed functions and programs are working. In addition, it will be attempted to redesign the project objectives during the project implementation process.

At the next stage, experience and know-how attained, as well as the system established through the process of first stage, will be expanded to other areas.

The following stage will be to apply lessons learned from initial stage (how to implement the pilot study, how to achieve the result successfully) to the planning of the programs for the expansion processes.

The personnel participated in the initial stage such as managing and financing personnel, physicians, nurses, para-medical staff, operation and maintenance staff should be involved during the expansion stage to motivate the participants of expanded areas, moreover to guide and transfer the know-how.

It is prerequisite that the country has unified and standardized administrative local units in any regions, when expanding the efficient and appropriate medical services established and attained in the pilot areas to other areas. In other words, administrative units in pilot areas are required to be identical with those of other areas so that redesigning of the programs will be possible for further expansion.

Pilot study aiming at the improvement of medical services at both Oblast and Rayon levels conforms to the decentralization movement of this country, and to the future strategy to improve medical services at national level.

Specifically, in the short term, the pilot study projects at Rayon and Oblast level will be implemented. In the medium and long term, expansion of these projects will be attempted from pilot Rayons to others Rayons, and from pilot Oblast to others.

On the other hand, note that the objective of the pilot study project is not to input much resource to the limited areas, but to emphasize the implementation of the well-designed programs, the capacity and institutional building of the system, and transferring of know-how, all of which are expected to be expanded into the others areas. Thus, it is critical to determine the optimum resources input, and to design viable programs.

CHAPTER 16
PRIORITY PROGRAMS

16. PRIORITY PROGRAMS

(1) Main Concepts for the Formulation of Priority Programs

1) Sector-wise Approach to the Existing Medical Services

The first step of the priority programs is to analyze the situation of health care and medical services system by sector, existing in Uzbekistan. This approach clarifies and analyzes the weakness and strength of each segment of health sector. From those output, priority programs of the sector-wise improvement are formulated. Detailed descriptions of each sector's situation analysis and improvement programs are shown in the Chapter 15.7.1. Main sector of the situation analysis and formulation of improvement program are shown below;

Table 16.1 Sector of Situation Analysis and Formulation of Improvement Program

1. Health Financing (including Health Management System and Legislative Base of Health)
2. Referral System (including Quality of Medical Services)
3. Health Information System
4. Medical Facilities and Equipment
5. Drug Supply
6. Human Resources Development
7. Primary Health Care (including Health Promotion, Maternal and Child Health Care, Sanitation, Hygiene, and Infectious Diseases Control)

2) Comprehensive Approach for the Medical Services

For the consideration of improvement of the national level health care and medical services, it has to examine all sectors related with health care and medical services and formulate the comprehansive improvement program, which cooperates and collaborates among each sector. Because, improvement of the health situation is not able to achieve the individual sector programs.

Therefore, for achieving the overall goal "improvement of the national health situations of all population in Uzbekistan", this M/P recommends the comprehensive improvement programs in accordance with three Objectives for M/P formulation.

Comprehensive improvement program is to be considered with area-wise approach including country-wide level. Componets of health care and medical services

improvement in the certain area are categorized with medical service level (primary, secondary and tertiary level referral), beneficiaries and community level and other items which related with all the health care and medical services systems like a health finance. Therefore, for achievement of three M/P objectives (see Chapter 15.5.2), overall and comprehensive improvement programs for the area level, each medical services level, community level and other items (related with all system) were considered.

The concept of the comprehensive improvement program is shown below;

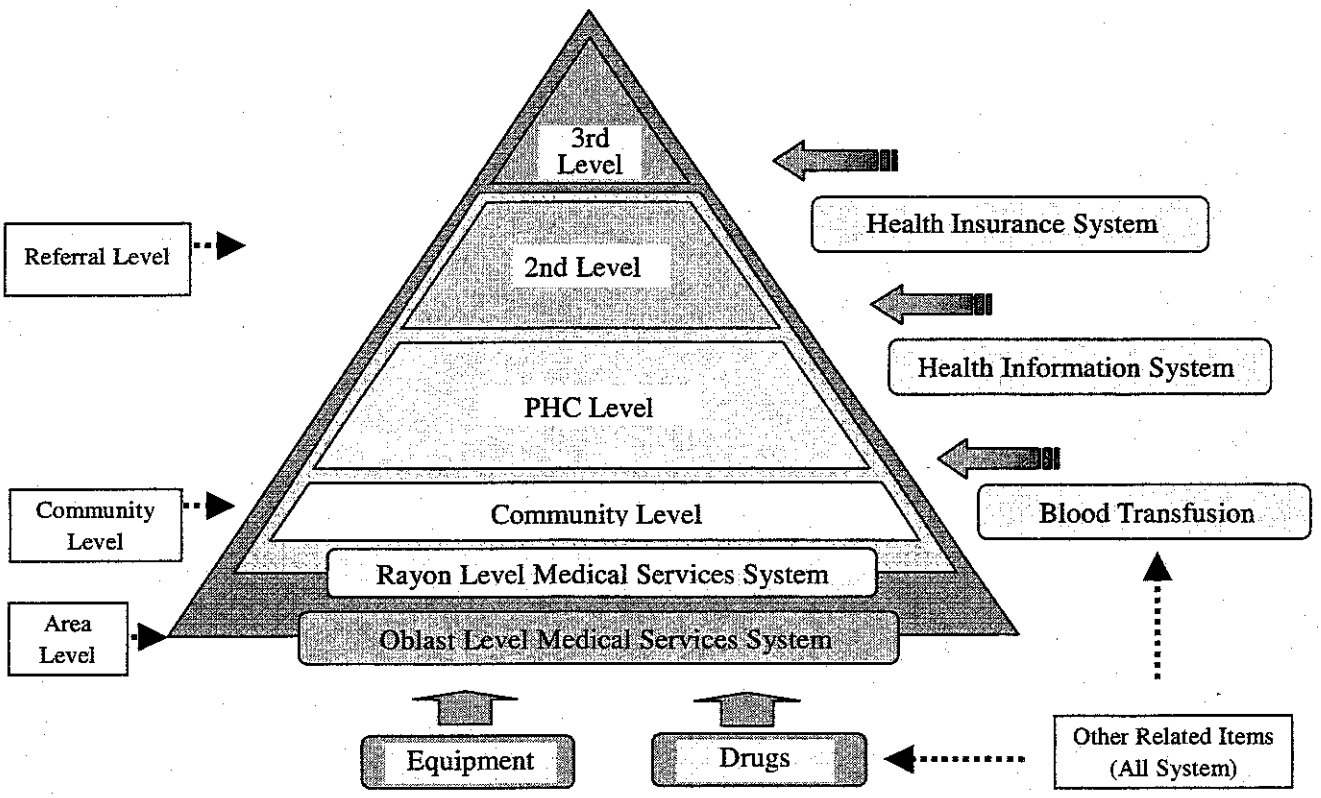


Figure 16.1 Concept of the Comprehensive Program

(2) Stage-wise Development Approach; Time Scale

After the formulation of improvement programs through the process of above-mentioned approaches, priority programs of this M/P were selected in accordance with achivement of three M/P objectives, effectiveness, time scale of the implementation. Priority programs and planned period, scale of priorities are shown in the table below. Meanwhile, criteria for the acheivement of objectives and relation with objectives, related health sector for improvement and priority programs are described in the follwing chapter.

Table 16.2 Timetable and Priority of Improvement Programs

	Items	Short ~2005	Mid-Long Term (Target Year) 2006~2010	Super Goal ~2015*	Priority **	Assumptions and Required Conditions
PHC Level	Strengthening of PHC				-	Top priority of PHC
	1) Strengthening of SVP (Health Project & ADB Project)				AAA	Wide range expansion for implementation Simple implementation package
	2) Improvement of rural healthcare services by collaboration with SVP & CRH **19.3 Strengthening of medical services in Rayon level medical services system**				-	Development of SVP is the priority
	a. Pilot Project				AAA	The area where SVP needs to be up grade
	b. Expansion to national level				AA	Wide range expansion for implementation
2nd Level	**19.3 Strengthening of medical services in Rayon level medical services system**				-	Top priority of MCH & rural health development
	1) Strengthening of MCH (ADB Project)				AAA	The budget is to be allocated by ADB
	2) Improvement of medical services in CRH				-	Needs for MCH/ anemia control CRH is key facility of rural medical services
	a. Pilot Project				AAA	Small scale trial can be adopted
	b. Expansion to national level				AA	Wide range expansion for implementation
3rd Level	**19.4 Strengthening of Oblast level medical services system**				-	Needs for integration for subdivided hospital function
	1) Establishment of effective medical services system in Oblast level				-	Operation cost is reduced by project implementation at project site facility
	a. Pilot Project				AAA	Pilot must be carefully chosen for feasibility
	b. Expansion to national level				AA	Cost allocation does not meet with solution
All System	**19.1 Strengthening of health financing**				AAA	Top priority of improvement of health financing Integration with "Health II" project for management training
	19.2 Establishment of health insurance system				-	Area-wise category must be considered due to economical gap
	a. Pilot Project				AAA	Pilot must be carefully chosen for feasibility
	b. Expansion to national level				AA	It takes long term to permeate equally
	19.6 Improvement of Blood Transfusion System				-	Needs for MCH/ anemia control Needs for infection control Need for blood security

Items	Short ~2005	Mid-Long Term (Target Year) 2006~2010	Super Goal ~2015*	Priority **	Assumptions and Required Conditions
a. Pilot Project				AAA	Adequate scale of population (1~3 Oblasts) can be adopted
b. Expansion to national level				AA	Cost allocation must be considered
19.5 Establishment of Health Information System				-	Priority of health information system for health strategy & plan
a. Training to RIAC & establishment of System				AA	Integrated with donors activities for health information system
b. Training rural staffs & expansion to national level				AA	Integration with "Health II" project using SVP/ CHR lab & PC Cost allocation must be considered

Remark : Monitoring & evaluation period
Short term programs

Note: * The system of health care reform and medical services strengthening to be established until target year of 2010. It assumes that the activities of expansion to countrywide of the established system by M/P and fixture of sustainable system will be continued up to 2015, that is a year of super goal achievement and out of the M/P target year. However, it is important to continue the improvement program activities.

** Priority, AAA is high

*** The number of program means number of priority programs of this chapter

(3) Relation with M/P Objectives and Priority Programs

Relation with M/P objectives, countermeasures for achivement of the objectives, related health sectors for implementing the programs of countermeasures and priority programs including each health sector are shown in the following table. In other words, this relation is also able to express the criteria of the priority program consideration, because this relation is directly connected with achivement of the M/P objectives.

Table 16.3 Relation with Objectives and Priority Program

Objectives	Countermeasures	Related Health Sectors	Program Title
A Humanity & Equity (Improvement of Quality & Equal Access of Medical Services)	Improvement of the quality of medical services and enhancement of equal access to medical services for all population	1. Health Financing (with Health Management System and Legislative Base of Health) 2. Referral System (with Quality of Medical Services) 6. Human Resources Development 7. Primary Health Care (with Health Promotion, Maternal and Child Health Care, Infectious Diseases Control)	16.2 Directions for a National Health Insurance Program for Uzbekistan 16.3 Improvement of Medical Services at Rayon Level 16.4 Improvement of Oblast Medical Services System and Oblast General Hospital 16.6 Improvement of the Blood Transfusion System
B Efficiency & Sustainability (Establishment of Effective Madical Services)	Establishment of effective system of medical services for the population's health	2. Referral System 3. Health Information System 4. Medical Facilities and Equipment 5. Drug Supply 6. Human Resources Development	16.3 Improvement of Medical Services at Rayon Level 16.4 Improvement of Oblast Medical Services System and Oblast General Hospital 16.5 Establishment of Health Management Information System 16.6 Improvement of the Blood Transfusion System
C Cost-Effectiveness & Sustainability (Improvement of Health Financing System)	Improvement of the effective use of the health financing and introduction of new financing mechanism	1. Health Financing 3. Health Information System 6. Human Resources Development 7. Primary Health Care (with Health Promotion, Sanitation, Hygiene, and Infectious Diseases Control)	16.1 A Master Plan for Health Financing: 2004–2010 16.2 National Health Insurance Program for Uzbekistan 16.3 Improvement of Medical Services at Rayon Level 16.4 Improvement of Oblast Medical Services System and Oblast General Hospital 16.5 Establishment of Health Management Information System 16.6 Improvement of the Blood Transfusion System

Also, the flow chart of the relation with three M/P objectives and priority programs is shown below;

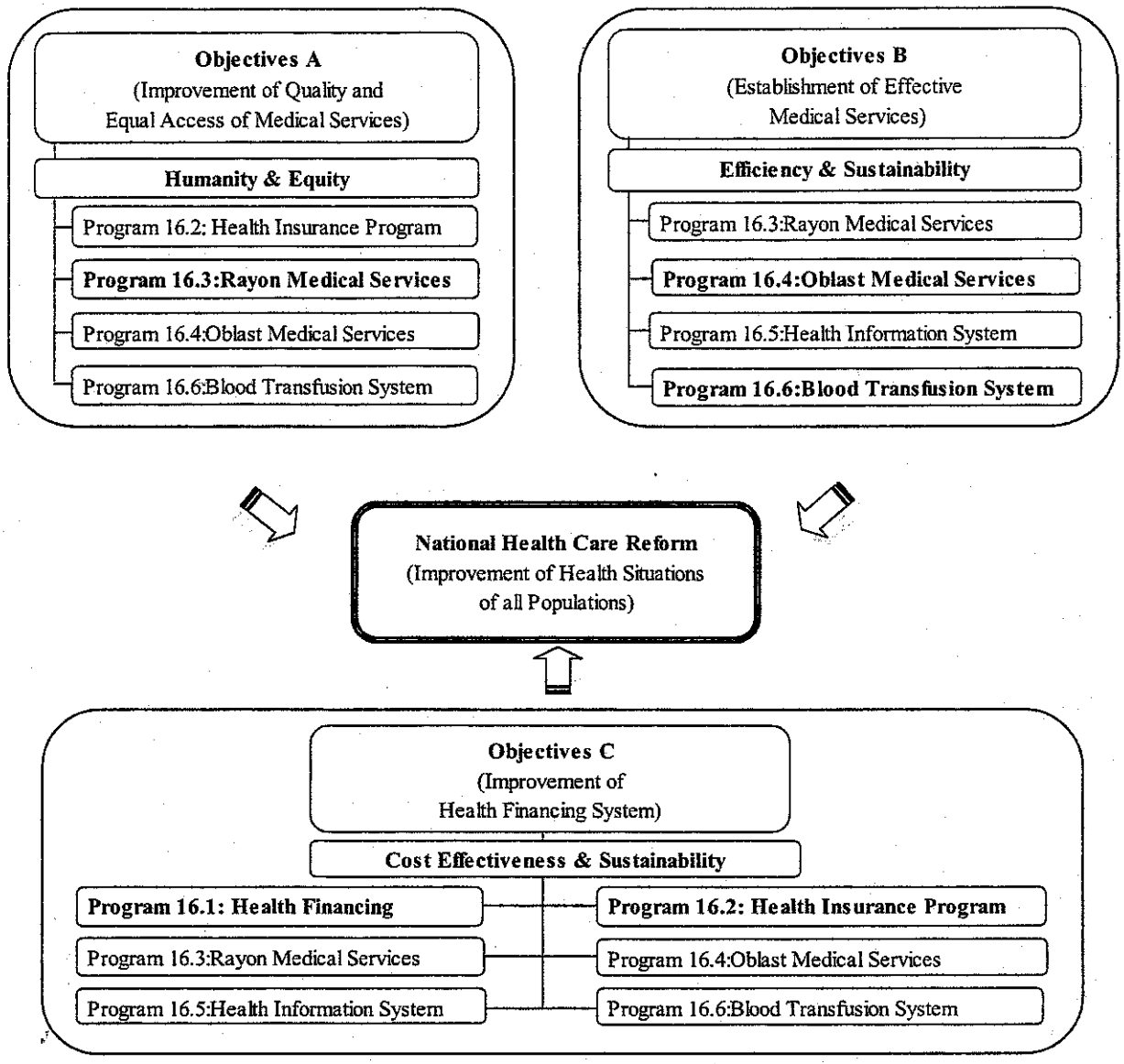


Figure 16.2 Relation with M/P Objectives and Priority Programs

16.1 A Master Plan for Health Financing: 2004–2010

This report is in two parts: the first part describes the over-all plan in a logical framework and activities. The second part discusses the directions for the over-all health financing reforms.

16.1.1 Over-all Goal

To develop a health financing system that will improve the capacity of the health sector to secure the health of the present and future generations of the Uzbekistan population

16.1.2 Background and Rationale: Need for Reform

In 1998, the Government of Uzbekistan embarked on a process of health reforms to improve the health of its citizens. An essential part of the reform process is health financing. Reform in health financing largely revolves around economic organization and building the health sector's material base. The entire reform process reiterates the government's commitment to continue and improve on the gains in health.

Reforms in Uzbekistan's health sector are under threat from low and declining levels of spending, a non-rational basis for allocation, unstable financial resources, a generous entitlement system and a vast health service organization. Reforms that seek to introduce more market elements like a pricing system and private health care providers are being undertaken without appropriate mechanisms to protect the more vulnerable groups.

Reforms in the budget allocation process are necessary; and an alternative system of funding, one that pools risks and costs across a population in the throes of social change, is needed. These reforms must seek to promote the necessary accountability, not only in terms of the use of resources, but also in terms of offering healthy lifestyle choices to the population. These reforms need to retain the equitable features of the 'old' system, while at the same time provide the resources and systems necessary to cope with new health challenges.

16.1.3 Objectives

For the year 2004–2010, the Health Financing Master Plan hopes to achieve the following objectives:

1) To improve the financial base of the health care system through budget allocation reforms across all levels of care, including free care;
2) To facilitate the establishment of a market in health services, while at the same time providing for clear mechanisms to protect poor and vulnerable groups;
3) To introduce risk pooling and purchasing elements in the health system through a third party or health insurance system; and
4) To strengthen capacities to develop, support, manage and monitor health financing system reforms.

16.1.4 Project Location

The proposed plan will be national in scope, but pilot tests and programs may be made at specific sites complementing other JICA interventions. Thus, the Study recommends that the sites be selected from the areas where the Baseline survey took place.

16.1.5 Target Beneficiaries

Activities which are national scope will benefit the whole country. Local and site-specific interventions will benefit specific communities and the people in those localities.
But the lessons from implementation will be useful for scaling up to the rest of the country.

16.1.6 Duration

The period covered by the plan is 2004-2010.

16.1.7 Implementing Agency

The proposed health financing activities will be overseen by the Ministry of Health, with general directions provided by a multi-sectoral body involving the Ministries of Finance, Macroeconomics, Statistics and the Committees of the Cabinet of Ministers and other agencies, which will be affected by plan processes and outputs.

The various activities contained here will be implemented by commissioned groups and individuals, both from within the country and outside.

16.1.8 Expected Indicators of Outputs (see logical framework below)

A logical framework presenting the above discussion, as well as the assumptions on the over-all environment under which the activities will be successful is given below:

(1) Health Financing: Logical Framework for the Plan Period (2004-2010)

Table 16.4 Logical Framework for Health Financing

Narrative Summary	Selected Indicators	Data Sources/ Means of Verification	Assumptions
Over-all Goal: To develop a health financing system that will improve the capacity of the health sector to secure the health of the present and future generations of the Uzbekistan population.	1. Improved share of public health expenditures in GDP as per scaling up guidelines of WHO (one-half of 1% increase per year).	- National Health Accounts reports	Political stability and government commitment to reforms (as evidenced by active inter-sectoral coordination in health financing); - Macroeconomic growth.
Objectives: 1. To improve the financial base of the health system to sustain the health reform process. 2. To support the establishment of market mechanisms in health services 3. To develop risk pooling and purchasing functions through health insurance 4. To strengthen the country's capacities to develop, support, manage and monitor health system reforms.	1.1 More diverse financial resources for health care by 2015 1.2 The procedure of capital investment is clear and regular. 2.1 Division-base financial analysis is executed regularly 2.2 The budget book is made. 2.3 The budget execution is appropriate. 3.1 Adoption of the National Health Insurance Program by 2015 3.2 The medical affairs business is appropriately done. 4.1 National Health Accounts is clear and opened. 4.2 Increased competences in health economics	- National Health Account Reports - Facility-level reports - Law on the National Health Insurance Program - National Health Accounts - Five (5) citizens with PhD in Health Economics	Financial reforms based on encouraging private sector participation and enhancing savings. Health Financing Unit established and 'shepherding' activities under this plan.
Outputs 1. Alternative strategies and systems to allocate public and private budgets for health care designed, implemented and evaluated	1.1 Community -level initiatives to support SVP reforms by 2015 1.2 Improved resource allocation formulae adopted for national, oblast and rayon budgets 1.3 Governance reforms	- Health expenditure data for each level of facilities; - Reports - Reports	- Sub-national (Oblast and Rayon – level reports)
2. Development of an exemption and regulatory framework for market operations	2.1 Exemption guidelines and coverage of this guideline 100% by 2015 2.2 Regulatory framework and supervision 2.3 Self-financing in selected facilities	- Exemption guidelines - Copy of laws and implementing guidelines' - Revenue reports and investment data	

Narrative Summary	Selected Indicators	Data Sources/ Means of Verification	Assumptions
3. Development of a National Health Insurance Program Plan, edict, and systems	3.1 Law on State Medical Insurance Program by 2015 3.2 Basic infrastructure for health insurance in place	-Law -Organograms -Systems	
4. Improvement of national and local capacities to design, implement and monitor health reforms	4.1 A system of National Health Accounts 4.2 A health finance policy unit within MOH 4.3 5 Health Economics PhDs 4.4 Training, and study tours for each Oblast 5 key persons	- National Health Accounts, - Training Plans - Evaluation Reports - Report	- Inter-ministerial cooperation - Selection of trainees based on merit - Trainee feedback and performance monitoring systems in place
Activities	**Inputs** **[Donor]** - Technical assistance, including. resident management TA teams - Civil works, Supplies & Equipment (including computers) - Training, research grants, IEC and study tours - Educational grants for PhD - Vehicle for health finance unit - Start-up costs of health financing unit - Seed money for "contests"	**[Counterparts]** - Top-level counterparts; - Middle-level staff in newly established Health Finance Unit, with expense support for travel and supplies; - Office space - Workshop venues - Vehicles for monitoring visits	**Fundamental Assumption** - Political commitment to health reforms unchanged in spite of political or administrative changes. - Macro-economy continues to grow. - Donor commitment to reforms does not waver. **Indicative Budget (US$)** 4,054,000

16.1.9 Project Components/Activities/Outputs/Means of Verification/Priorities

The table below shows the different activities to be undertaken during the Plan Period. The scaling of priorities should be viewed not so much to identify activities as diminishing in importance, but rather in terms of consequential timing. Some activities maybe designated as medium or third priority because their conduct and contents may flow from first priority activities.

Table 16.5 Project Component

Component/ Activities	Outputs	Project Type	Priority Scale (*** high)
1. Improvement of the Financial Base of Health Care System			
1.1 Guarantee of Free Package of Services			
1.1.1 Review of Benefit Package, Determination the Costs and Identification of Financial sources to support implementation	Benefits Plan	Costing Study	***
1.1.2 Determination of the Feasibility Having Multi-level benefit structure	Benefit Plan	Feasibility study	***
1.2 *Budget Allocation Reforms*			
1.2.1 Design and develop initiatives in community participation and financing to support SVP reforms	Community Health Initiatives	Pilot project	**
1.2.2 Development of and pilot test of improvements to public budgets resource allocation system to rayon, oblasts and republican centers	New resource allocation formulae and new budget systems; Unified, simplified reporting systems	Systems design, pilot test; 2.b Unified Reporting systems	***
1.2.3 Develop, design and implement grants and tender mechanisms for applied scientific research	Improved financing of scientific research	Systems design, implementation	**
1.2.4 Development of Quality Monitoring system for reformed areas	4 Monitoring System	Monitoring and Evaluation	**
1.3 *Mixed Financing Reform*			
1.3.1 Study on impact of mixed charging reforms on utilization by the poor and provider behavior	Impact Study on Poor and Provider Behavior	Research	*
1.3.2 Initiate Hospital Reforms, through systems development and governance pilots	Hospital Reforms	Systems Design, Pilot Tests and Training	**
1.4 Secure Foreign Assistance, investments and credits to the health sector			
1.4.1 Creation of a donor coordination forum	Improved Donor coordination	Coordination meetings	***
1.4.2 Design and support for 'contest-based' activity to bring out best practice, innovations in health service delivery, organization, policy and financing	Increased public awareness of reforms	Information, Education and Communications (IEC)	*
2. Introduction of Market Mechanisms in the Health Sector			
2.1 Introduction of a Price System in Public Health Care Facilities			
2.1.1 Develop and implement exemption mechanisms to public charging system;	Exemption Guidelines	Technical Assistance	***
2.1.2 Strengthening price introduction through Development and update price index for selected medical items	Updated Index of Medical Prices	Database development	*

Component/ Activities	Outputs	Project Type	Priority Scale (*** high)
2.1.3 Develop and Conduct Information campaigns and staff orientation for charging system	Information, Education, Communication (IEC) Plan	IEC	**
2.1.4 Conduct Operations Research to determine efficient multi-specialty rayon facility for facility integration	Reform Plan for Rayon-level Facilities	Operations Research, Institutional Reform, Training	***
2.2 *Private Sector Development Activities*:			
2.2.1 Development of a regulatory framework for facilities	Standards and Regulations for Health Facilities	Technical Assistance	***
2.2.2 Facilitate Privatization of Public Health Care Facilities			
1) Development of Business Plans for Specialist Centers of Surgery, Cardiology, Urology and Ophthalmology	Business Plans	Institutional Reform	**
2) Design and Implement alternative sale and management mechanisms for public health care facilities	Sale of and/or management contracting arrangements in identified public facilities	Systems Design, Study Tour	**
3) Review of laws affecting privatization efforts (labor, property use, disposal of property, financing)	Legal Reviews and draft laws	Technical Assistance	***
3. Development and Introduction of Risk Pooling and Purchasing through a Health Insurance program			
3.1 Planning the Development of a compulsory system of health insurance			
3.1.1 Consensus Building on health insurance systems	Compulsory health insurance plan	Workshops, Study Tour	***
3.1.2 Study to determine population coverage, contribution structure and payments	Actuarial Study	Technical Assistance	**
3.1.3 Studies to support design of provider payment schemes	Provider Payment System	Technical Assistance, Research Grants	**
3.1.4 Development of Systems for Purchasing: Accreditation, Information database, legal systems	Purchasing Systems	Technical Assistance	***
3.1.5 Determine organizational structure of the health insurance program	Organizational Structure	Technical Assistance	**
3.1.6 Development of system of grievance, complaints and arbitration	Development of user-friendly public services	Technical Assistance	**
3.2 Development of the Legal Base for the program			
3.2.1 Draft Law for compulsory health insurance	Law on National Health Insurance	Technical Assistance	**
3.2.2 Development of Implementation Guidelines	Legal/Administrative Study	Technical Assistance	**
3.2.3 Stakeholder orientation and training	Information, Education, Communication	IEC, Training	**
3.3 Development of Information Systems and reporting forms for Health insurance	Membership data base, Financial systems, Quality assurance systems: utilization, referrals	Systems Design, Training, Study Tour, Equipment	*

Component/ Activities	Outputs	Project Type	Priority Scale (*** high)
4. Strengthening Capacities for Health Financing Reforms			
4.1 Adoption and installation of a national health accounts system to monitor system performance			
	National Health Accounts	Technical Assistance	***
4.2 Capacity building activities to implement and manage a health reforms			
4.2.1 Training Needs Assessment (TNA) for Health Financing and Policy	Training Needs Assessment	Technical Assistance	***
4.2.2 Conduct of Training Activities as identified in TNA	Training Needs Assessment	Technical Assistance	***
4.3 Creation of a Core Health Financing Group within the MOH			
4.3.1 Organize a health financing unit with nominations from MOH and non-MOH bodies;	Health Financing and Policy Unit	Institutional Reform	***
4.3.2 Selection, Support for and Education of 5 PhDs in Health Economics	Five (5) PhD in Health Economics	Education Grants	***

Table 16.6 Timetable of Implementation

Activity Number		2004 -2005		2006 – 2008			2009– 2010	
0	**1. Preparatory Activities: 2003**							
4.3.1 *4.2*	- Creation of and budget allocation for Health Financing Policy Unit - Training Needs Assessment							
4.3.2	1.1 Selection, Deployment of Scholars							
	1.2 Donors' Coordination Forum	X	X					
	1.3 National Health Accounts:	X		X			X	
1.4.1	Installation and Training,						X	
4.1	Regular Updates	X	X		X			X
	2. Benefits Planning							
1.1.1	- Review of Guaranteed Package	X						
	- Recommendations on Benefit and Financing	X						
1.1.2	Structure							
2.1.3	- IEC		X	X				
3.1.2	- Actuarial Determination		X					
2.1.2	- Price Index Development and Monitoring of Benefit Items		X		X		X	
	3. Regulatory Review/ Reforms							
2.2.1	- Standards and Regulations for Health Facilities &	X	X					
	- Dissemination Activities			X	X			
2.2.2.3)	- Review of Laws affecting and recommendations for privatization / law passage/ implementation	X	X					
	4. Budget Reforms							
1.2.2	- Review of recent initiatives and formulation of new resource allocation guidelines	X	X					
	- Pilot Testing			X				
	- Roll-out & Dissemination		X	X	X			

Activity Number		2004 -2005		2006 – 2008			2009– 2010	
1.2.3	- Guidelines for allocation to Scientific Research		X					
	5. Protecting the Poor Initiatives							
1.2.1	- Design and Develop Initiatives in Community Participation & Financing		X	X	X	X	X	
2.1.1	- Exemption Guidelines & Implementation/ Monitoring	X	X	X		X		X
1.3.1	- Study Impact of Mixed Charging			X				
1.2.4	- Quality Monitoring for Reformed Areas		X	X	X	X		
1.4.2	- IEC Activities/"Contests" to bring out local level initiatives			X	X			
	6. Facility-level Reforms							
1.3.2	- Review, Design, initiate hospital reforms and governance pilots	X	X	X	X	X	X	X
2.1.4	- Conduct Operations Research to determine Efficient Multi-specialty rayon level facility - Training - Roll-out Institutional Reforms	X	X	X X	X X	X		
2.2.2.1)	- Business Planning for 4 Self-Financing Specialist Centers	X	X					
2.2.2.2)	- Design and implementation of new disposal mechanisms for public health facilities		X	X	X			
	7. Planning the Development of A compulsory Health Insurance System							
3.1.1	- Consensus Building Activities; Study Tours	X						
3.2.1	- Draft Law on Compulsory Health Insurance (after actuarial study above)			X				
3.1.3	- Design Systems for Provider Payment : Case identification, costing studies, determination of scheme	X	X	X				
3.1.4	- Development of Purchasing Systems: Accreditation, Legal Systems, provider data base	X	X	X	X			
3.1.5	- Organizational Structure & Staffing Study of Health Insurance Program			X				
3.1.5	- Systems of Grievance, Complaints and Arbitration			X				
3.2.2	- Implementation Guidelines				X			
3.2.3	- Stakeholder Orientations/ Training				X	X	X	X
3.3	- Information Systems and Forms			X	X			
	- First Transfer of Funds/ Enrolment					X	X	
0	- Evaluation of Reform Process				X		X	

16.1.11 Management Issues

The following assumptions are held regarding project management for this component:

The creation and funding of a Health Financing Policy Unit (HFPU) within the Ministry of Health is to provide project oversight.

Its tasks basically involve, among other administrative functions, the following:

a) Drawing-up a work-plan to implement plan;
b) Preparing of terms of reference for project activities;
c) Initiating activities necessary to carry out plan;
d) Coordination of activities, within the scope of the plan and across sectors;
e) Facilitating conduct of activities with other units of MOH and the government and other donor activities;
f) Monitoring progress of work;
g) Provision of regular reports on the plan's progress, activities and output; and
h) Facilitating technology transfer to the different units of government.

A Head of Unit will be appointed and directly responsible to a Deputy Minister. The work of the Unit will be guided by a Steering Committee drawn from the original Working Group on Health Finance.

Donor funding will provide the managerial support and technical assistance over the work of the Unit. It can be spun-off from existing programs or drawn from entirely new resources.

Commissioning of the work to various groups and individuals in the country and outside will be done in a competent and transparent manner.

Data and materials drawn from the conduct of work will be the property of the government and will be available to researchers.

16.1.12 Investment Plan/ Budget

This is an indicative budget and excludes overhead, other expenses associated with expatriate management costs and software acquisition or rights costs. Price adjustments due to inflation were also not factored in. Estimates were based on international rates.

Table 16.7 Investment Plan by Critical Inputs (In thousand US $)

	Civil Works	Equipment	Training	Staff	TA	Research	Supplies	Others*	Total
1. Improvement of the Financial Base	65	26	185		299	100		175	850
2. Market Reforms			20		293	30		100	443
3. Development and Introduction of Health Insurance		100	180		590	280		140	1,290
4. Strengthening Capacities for Health Financing Reforms	32	47	910	336	62		84		1,471
Total	97	173	1,295	336	1,244	410	84	415	4,054

Note : Others include IEC, study tours, seed money for 'contest'
TA; Technical assistance

Table 16.8 Investment Plan by Period (in thousand US $)

	2004	2005	2006	2007	2008	2009	2010	Total
1. Improvement of the Financial Base	235	105	290	175	15	25	5	850
2. Market Reforms	170	183	30	10	20	20	10	443
3. Development and Introduction of Health Insurance	172	368	465	215	45	15	10	1290
4. Strengthening Capacities for Health Financing Reforms	691	460	80	60	60	60	60	1471
Total	1,268	1,116	865	460	140	120	85	4,054

16.2 Directions for a National Health Insurance Program for Uzbekistan[1]

16.2.1 Introduction

This paper presents a framework to determine directions for the evolving health financing system in Uzbekistan. The framework is used to analyze current patterns of financing in the health sector, in order to appropriately situate the proposed reform areas. Given the early stage of discussion, responses to the framework will help evolve a consensus that will

[1] A major part of this report was presented before a Health Financing Working Group Meeting, June 2003.

shape the directions in health financing for the proposed Master Health Plan.

The Presidential Edict of 1998, which outlines the state program of health care system reform in Uzbekistan, is used as a guide to understand the nature and intent of reforms. This paper hopes to contribute to the roadmap for health finance reforms in Uzbekistan, particularly in health insurance.

16.2.2 A Health Financing System Framework

Figure 16.2 illustrates a health financing framework that takes into account health systems, financing functions, and financing sources. It is often the case that the funding source identifies the health system. So, for example, a financing system largely based on taxes points to a national health service delivery system, like in the United Kingdom or Canada. Functions (discussed in WHO World Health Report in 2000 on Health Systems Performance) or institutions transforming funds into actual resources for health care are important determinants of the achievement of health system objectives. These objectives are not included so as not to clutter the framework. Standard health system objectives are listed in Box 1.

Box 16.1: Health System Objectives

***Equity*:**

- Those with similar needs get similar access to services—EQUITY IN PROVISION
- Those with greater capacities bear greater burden of payment than those with less capacity—EQUITY IN FUNDING

***Efficiency*:**

- Use of cost-effective methods to provide services—TECHNICAL EFFICIENCY
- Use of funds to achieve maximum health gain—ALLOCATIVE EFFICIENCY

Sustainability:

- Affordable or can be supported by available resources—STATIC;
- Capable of generating resources to meet needs—DYNAMIC

Quality:

- Degree to which actual care delivers anticipated results, assuming professional standards of service delivery

Responsiveness - degree to which needs by consumers or providers are met

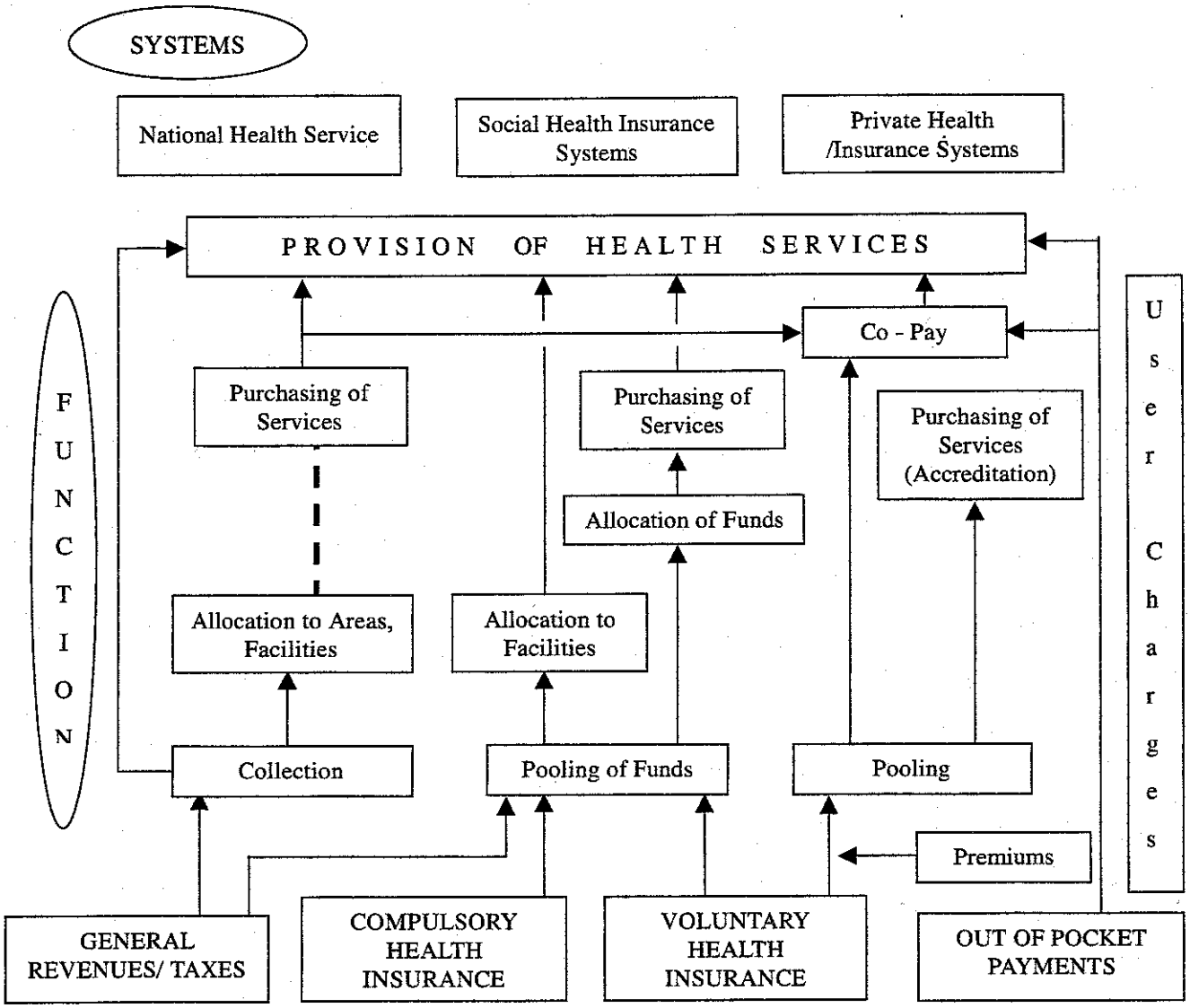


Figure 16.3 A Functional-Systems Framework for Health Financing Reforms

There are four major sources for funds:

1) General revenues of national or local governments largely generated through taxes;
2) Compulsory health insurance or mandatory insurance schemes. Payment for such obligatory systems is considered a tax.
3) Voluntary health insurance schemes which are entered into and paid by individuals or other groups on behalf of individuals; and
4) Out-of-pocket payments, which are individual or household payments made to procure a service. The payments are in the form of user charges (direct payments) or premiums for insurance coverage. Out-of-pocket payments may also be official co-payments for service charges or unofficial payments, or payments made to staff or for items which normally would be free.

Any health financing system undertakes four major functions. These include: fund collection, pooling of funds, allocation of funds and purchasing of care. (See Box 2 for a definition of these functions.)

Box 16.2 Definitions of Health Financing Functions[2]

Revenue Collection: A process of mobilizing resources, usually through taxation of individuals, businesses, corporate entities, and mobilizing donor/creditor funds.

Pooling of Funds: Spreading of the financial risk across the population or sub-groups of population through accumulation of pre-paid health care revenues.

Allocation: The process of distributing funds to facilities or areas normally associated with budget funds.

Purchasing: Process of obtaining services from providers on behalf of the covered population; usually done through contracts.

[2] Adapted from Dixon, Langenbrunner and Mossialos, 2002. "Facing the Challenges of Health Care Financing," A Background Paper Prepared for USAID Conference, July 29-31.

Health systems vary depending on the way these functions operate in the health finance system. There are three major health financing systems: the national health service system, the social health insurance, and the private health or insurance systems. The National Health Service of the United Kingdom. exemplifies the first system, which is characterized by entirely government funded health services. Providers are paid salaries and allocation to facilities are based on a formula that includes population size and health needs requirements. A tax-based system is generally believed to be more equitable than other systems. However, such health systems have also been marked by inefficiencies and inequalities that include, among others, problems in accessing specialist care, long waiting lists, and inequalities in health outcomes.

Purchasing arrangements, like for example in the UK, have local authorities no longer directly managing hospitals and community health services, but purchase or commission these services from providers. Facilities with whom they can contract with are presumed to offer cost-effective services because they have gained operational and some financial autonomy as Trust entities. Trust and fund-holding status are however based on certain specified criterion and not available for everyone (Payne, 2001). Purchasing

arrangements require specific skills in epidemiology to identify needs and some health technology assessment tools to assess new service developments.

Compulsory arrangements through payroll tax or other earmarked tax sources, ensure that tax revenues pay for health care and that populations have access to state-sponsored health insurance, but the care is not necessarily provided by state-owned facilities. There are two main types of Social Health Insurance-based systems: a) the integrated system, where the funders or insurers own the facilities under an integrated system—quite common in Latin America; and b) where providers and insurers are separate, as in Germany and Japan. Often, under the latter, there are various pools of funds known as sickness funds or regional funds, where fund holding allows contracting with facilities for the provision of services to their members. These fund holders are able to negotiate for the price of services usually based on case payment or case-mix adjusted payments, global budgets or fee for service.

A private system operates when a sizeable portion of the health care expenditure is met by individuals or their sponsors, like employers, under the voluntary health insurance systems. Private systems would best be illustrated by the systems in the United States. Although the United States has social health insurance arrangements through Medicare (health insurance for the elderly) and MedicAid (for the poor), a system of accreditation is widely used for purposes of quality assurance (not all facilities can receive pooled funds). Accreditation is a system whereby a facility which meets certain professional standards is granted recognition. Those receiving pooled funds are paid on negotiated fee for service rates or case-mix global budgets or direct case payment. The system has also devised sophisticated payment methods, like Diagnostic Related Groups (DRGs), and Relative Value Resource Based Scales (RVRBS), which analyze the range of resources used per diagnostic group and charges accordingly.

Table 16.9 summarizes a theoretical discussion on the advantages and disadvantages of the funding mechanisms.

Table 16.9 Advantages and Disadvantages of the Different Methods of Funding Health Care[2]

Method of Revenue Collection	Advantages	Disadvantages
Taxation: Direct	• Wide revenue base (all income) • Administratively simple • Usually progressive and promotes solidarity • Large risk pool • Universal coverage • Allows expenditure control	• Compliance difficult, esp. if large non-formal sector • Applications subject to political negotiation • Potential tax distortions
Indirect	• Visible source of revenue • Administratively simple • Wider compliance	• Potential tax distortions • Allocations rely on consumption levels • Usually regressive
Social Health Insurance	• Earmarked for health • Separate from other government revenues • Contribution linked to benefit • Low resistance to increases • Independent management of funds • Potential for expenditure control • May allow choice of insurer • May employ redundant health workers	• Compliance difficult esp. for fund transfers • Increases cost of labor and reduces international competitiveness • Revenue follows economic cycle • Strong regulatory framework needed • Narrow revenue base (if applied only to earned income)
Voluntary Health Insurance	• May allow choice of insurer • May relate payment to utilization	• Strong regulatory framework needed • Adverse selection (results in escalating premiums) • Risk selection (leaves some uninsured) • Access related to insurance cover • Usually regressive
User Charges/ Out-of-Pocket Payments	• Relates payment to utilization • Consumer-responsiveness	• May deter access to necessary services • Access related to ability to pay • Regressive • Limited pooling of funds

Maximizing on the advantages and minimizing on the disadvantages often depends on the changes in behavior of providers and consumers as a result of the systems' incentives. The type of provider payment system that is adopted is therefore crucial. Fee for service presents a serious challenge to administrative systems, negotiating instruments and cost-control mechanisms.

Capitation payment is a widely used allocative and purchasing tool under all systems. It

[2] Adapted from Dixon, Langenbrunner and Mossialos, 2002.

refers to a fixed payment to a provider based on a list or the number of people enrolled at a specified period of time; and the payments do not vary based on utilization. For patients in a system in which primary care is capitated, the choice of the provider is critical as primary care can only be sourced from this provider. Insurers prefer capitation for its administratively simplicity. There are no reimbursement claims to process. Providers prefer capitation because they are free to decide the treatment pathways and a fixed income is assured. Other aspects like prescriptions and diagnostics may present some problems and would require quality monitoring systems.

Global budgeting is a system based on performance of outputs and inputs. Unlike line-item budgeting, an all inclusive amount is agreed on by the funder and fund recipients at the outset itself. The budget serves as an effective cap or limit to health care expenditure.

Case-mix payments are fixed payments for a package of care provided according to diagnosis and average system of provision of care. Payment is made depending on the severity of illness measures. DRGs (Diagnostic related groups) or HRGs (Health care resource groups in the United Kingdom), are examples of such payments. Per case payment has resulted in prices being drawn up for disease categories. Payment rates may be based, budgets, norms, or simply budget availability. Among countries in Central and Eastern Europe (CEE) and Newly Independent States (NIS), per case payments have been developed for Bulgaria, Czech Republic, Hungary, Kyrgyzstan, Kazakhstan, Poland, Romania, and Slovakia, among others. Lithuania and Estonia are still in the process of developing such a system. The Russian federation is noted to have from 50, 000–55,000 payment categories; Kyrgyzstan 154, and Hungary 758.

Pooling arrangements in systems that have strong regional authorities may lead to fragmented arrangements and lessen the power of the pooled funds to purchase services; it could also give rise to accountability problems. Purchasing agreements have been shown to be cost-effective and enhance responsiveness to patients' needs. Private pooling arrangements are known to select only good risks.

A good institutional and incentive mix is therefore necessary to maximize the potential of the different funding systems. Payment schemes are often combined with utilization reviews, national payment setting and publication of charges, among other schemes—all

designed to ensure greater transparency and accountability.

16.2.3 The Current Health Financing System in Uzbekistan

The interim report highlighted certain observations regarding the current health financing system in Uzbekistan. Figure 16.4 places the Uzbekistan system within the framework outlined above.

(1) General Discussion of the System

General revenues from taxes form the base of the health finance system. In the interim report, it was shown that fund allocation is based on norms and standards determined centrally and adopted nationwide. The system of allocation provides for strong financial controls and is administratively simple. However, the allocation system is insensitive to differing health needs and is based on capacities of existing systems, which is determined by the number of beds and bed-days of patients.

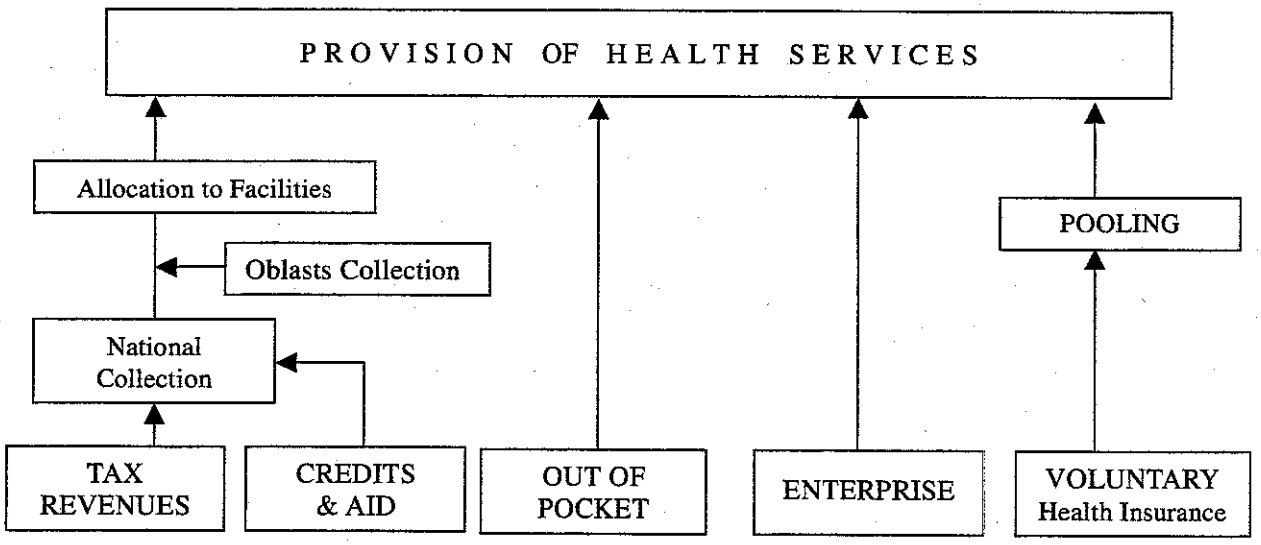


Figure 16.4 An Overview of the Current Health Financing System in Uzbekistan

Such allocation encourages facilities to focus on increasing bed capacity and longer bed-days stays, resulting in a demand for more resources to manage and maintain the facilities. With the existing macroeconomic constraints, such a system is unsustainable. Table 16.8 shows the trends in budget allocation. Budgets for salaries have increased over the years, allocations for other budget items have remained the same or declined.

The recent experiment on primary level capitation payment, which is being scaled up, is a step in the right direction as it channels resources to a level generally perceived to be cost-effective. However, new payment mechanisms under an old allocation system have their problems, which include, among others, additional paper work, increased transport costs for monthly reporting to oblast centers, payment delays and supply deficiencies.

Scaling up should not unquestioningly accept current locations of facilities but re-examine location plans, since simply reconstructing on an old site will result in a proliferation of facilities that may not be cost-effective. The absence of quality monitoring systems can also present problems that may undermine the credibility of the evolving system.

Table 16.10 Breakdown of Health Sector Budgets of the Ministry of Health, Uzbekistan

(figures in percentage except when otherwise indicated)

	1998	1999	2000	2001	2002
Total (mill. Sums)	41.7	56.7	82.1	119.4	173.5
Salaries	36	58	58	42	63
Utility Expenses	12	12	9	9	7
Food	10	9	9	9	9
Pharmaceuticals	12	11	10	10	10
Equipment	8	2	3	2	2
Materials & Supplies	2	1	1	1	0
Capital Repairs	3	3	5	4	2
Miscellaneous	17	4	6	23	6

Note: Presentation to the March 6 meeting of the Health Financing Working Group by MOH

From Figure 16.4, one observes that there are more funding sources than typical model shown above (Figure 16.3). The country can seek external assistance for budget support, either through loans or humanitarian aid, or from enterprises which provide health benefits to workers. The interim report reveals that external assistance in 2001 totaled $16 million and with the inclusion of humanitarian aid, it was US $38.6 million, or about 8 percent of the health funds. The figure rose to 20 percent in 2002 as shown in an earlier discussion (Section 5.7 of this report). The humanitarian aid and loans were used for the pharmaceuticals stocks. External assistance presents two challenges to the health system. First, the funding is not sustainable; and second, it is dependent on policies and priorities determined by donor organizations outside the country. More active donor coordination at the Ministry of Health level can insure against the latter risk.

Enterprises can be viewed as largely self-financing; they have their own health facilities, which employees, officers and their families can access. In the long-run, it is going to affect the competitiveness of Uzbek products and services as expenses for enterprise health facilities contribute to the costs of production. Enterprise financing is largely independent and therefore represents a parallel system. Therefore, currently, a dual system exists: on the one hand, you have the well-funded health units, with the latest equipment, for a few employed groups, and, on the other, under-funded, deteriorating public facilities for the majority. This raises questions about equity. There is no monitoring of quality, technology and cost monitoring by outside bodies. However, under a reformed system, enterprise facilities can also be considered as resources to be tapped.

There is a limited pooling of funds through the private insurance system. The population group covered by the insurance includes individuals, and some families who do business with the other trade units of the major insurance firm, UzbekInvest. There is also a facility-based pre-payment in some private health facilities.

Out-of-pocket payments are widespread in the system, whether official or unofficial. The 1998 reform initiative identified a number of facilities that are allowed to charge for their services. There are around 200 facilities in the process of introducing a user fee. The system is too young to be evaluated, but certain concerns may be raised:

a) Do the prices have a cost basis? (or Are the charges linked to costs?)
b) Are the revenues realized from these charges huge enough to make an impact on finances?
c) Is there sufficient accumulation of revenues? Does the system allow the facilities to save and re-invest?
d) Is there a system of exemption in place?

(2) Purchasing and Pooling Funds through Health Insurance

The challenge therefore for the Uzbek health finance system is not only to seek additional funding sources but ensure that these resources are effectively and efficiently managed. This can only be made under efficient structures of delivery and financing..

Figure 16.5 illustrates the missing element in Uzbekistan's system—active purchasing—and the very limited pooling base through voluntary private insurance.

Purchasing arrangements gained global prominence because of the concern regarding inefficiencies with public budget systems. For Uzbekistan, payments from taxes alone do not foster efficient behavior from providers, as structural changes still need to be made, especially in terms of changes in the referral structure and streamlining of facilities at the rayon and republican levels, among others.

The following are the arguments for the creation of a health insurance system in Uzbekistan. A health insurance system will help:

- to pool funds and risks;
- to introduce a purchaser into the system, one that can improve health system performance through a system in which 'money follows patients';
- to foster private sector growth;
- to capture the leakage in the system arising from private unofficial payments through the creation of a system of co-payments.

It is unlikely that the current health and medical structure in Uzbekistan will foster these changes. The argument for a parallel system is to provide a focus and ensure sustainability of reforms, one which can operate under more modern systems of management and a fresh mandate to bring about change.

(3) Experience of Countries in the Region with Health Insurance

Other countries in the Central Asian region, like Kazakhstan and Kyrgyzstan, initiated health insurance activities in the mid-90s. Analysts believe that this has been a distraction from more fundamental reforms in health delivery systems. Table 16.9 presents a summary of assessments based on the promises and what the insurance systems have actually delivered.

Table 16.11 Health Insurance: An Empirical Assessment*

Expectations	Reality
Tap extra revenue or secure earmarked funds for health.	Could account for only a small portion of the health system revenue. The problems that limit collection of taxes also limit collections in payroll-based systems. In Kyrgyzstan, insurance contributes to less than 5 percent of the state health care budget.
Funds would go into separate funds outside the traditional budgetary system and this would allow new ways of paying health care providers.	Unable to stop decreasing allocations to health budgets. Off-budget funds not adequately controlled; problem of corruption.
Insurance as a 'backdoor' for reforms.	This has only postponed the much needed reform of the entire government budgetary process. Public spending on health continued to decline.

Note :* Based on assessments of country experiences in Central Asia discussed in Health Care in Central Asia, by M. Mckee, J. Healy and J. Falkingham (editors), p. 185, European Observatory on Health Care Systems Series, 2002.

The European Observatory on Health Care Systems series has analyzed the experiences of different countries with health insurance. A brief summary of the analysis follows.

Turkmenistan has a government-run voluntary health insurance scheme since 1996. The scheme charges contributions of about 4 percent of gross income of the workers. Benefits include 90 percent discounts for prescribed drugs; 25 percent discount on dentures, guaranteed hospitalization for 7 days inpatient referral and free choice of family doctor. The system does not seem to have mobilized substantial resources; and since a fee is charged for drugs, it has resulted in cost escalation in the health sector.

Kazakhstan introduced a health insurance law in 1995 and in 1996-1998 experimented with mandatory health insurance. Compulsory health insurance premiums were collected to set up an off-budget fund; and received both payroll taxes and transfers from the state budget. A substantial 57 percent of the total public spending on health was fund transfers and half come from payroll taxes. However, a decline in the over-all health budget was observed. The health insurance system was transformed into a purchasing agency.

In Kyrgyzstan, health insurance received funds from payroll taxes only during its first three years. It was popular in the beginning, and grew rapidly. However, this rapid growth was

also viewed as the reason for its downfall. It was introduced before the legal and regulatory base was adequately in place and institutional capacity had been developed. Initial missteps and frequent changing of policy led to skepticism and over-all lack of trust in the system.

Only Kyrgyzstan appears to have a viable system in place at the moment. However, it is too early to dismiss the health insurance option on the basis of its disappointing performance and roll-back occurring in the neighboring countries. Focusing too much attention on it and neglecting other delivery reforms could also be the reason for its lackluster performance. In some instances, there may have been pressures to yield immediate results, like significant changes in the proportion spent on health. But a review of health insurance in the developing world would tend to support that a learning curve exists in the industry (Peabody, 1999). It generally takes time for the systems to be fully operational, utilization to adjust and funds to be accumulated. Macroeconomic considerations are also important as over-all economic growth provides the resources needed for start-up.

To sum up, concerns with regard to declining public health budgets can be allayed, if over-all health spending increased through third-party funding. A national health accounts system could capture these off-setting expenditure patterns. Social health insurance contributions are being largely relied on in Croatia, Czech Republic, Estonia, Hungary, Slovakia and Slovenia. For these countries, revenue streams are less fragmented. Relating benefits and contributions is also a key to a sustainable system. While Uzbekistan comes from a "rights-based" perspective in terms of social provision, its resources have not been able to fulfill this social contract.

16.2.4 Considerations for Health Financing Reforms

(1) What can be learned from consumer decisions?

A preliminary analysis of the JICA Study household survey showed the following:

1) Despite an extensive system of health facilities, households have a limited choice when it comes to facilities. The major reason cited for choosing a particular facility is that it is the only source available.

2) This perception of limited choice may be explained by the largely specialist orientation of facilities. Different facilities respond to different needs. So, for example, primary care facilities (SVPs, etc) are used for pediatric care; emergency care facilities for sudden illness; polyclinics for chronic illnesses and Rayon hospitals for maternity and delivery cases. Oblast facilities appeared to be the least utilized.

3) The preferred method of payment is payment for the service accessed, with 69 percent of respondents preferring this mode. However, there are about 14 percent of the respondents preferred to make lump sum monthly payments. This is a hopeful number for pre-payment schemes like health insurance.

For insurance systems to be widely accepted, people need to understand the benefits accruing to them from such a system. However, for such an understanding to develop it takes time and requires resources for information, education and communication (IEC) campaigns.

From the survey, it becomes clear that the reforms should be directed towards: provision of choice, selective purchasing of care and some support for pre-payment among households.

(2) A Proposed Health Financing System for Uzbekistan

Figure 16.4 provides a perspective for the proposed health insurance system in Uzbekistan.

Features of the Proposed System:

1) The system comes into place gradually, allowing time for the following activities to take root:

   a. Reforms in alternative provider payment schemes for a reformed health delivery/ provisioning system. The ideal system for health delivery or provisioning must include: a) an efficient public health system (primary and tertiary) where financing and delivery is integrated, and where prospective per capita payment is the norm; b) a wider spectrum of care which is available in one location at the secondary level or where multi-specialty group practice is the norm.

b. Prepayment experiments at mahalla (lowest political administrative unit) levels and in some enterprises. This will be voluntary in the beginning, starting with mahallas that are the subject of SVP reforms and construction, and in some enterprises that have seen some growth recently. Even enterprise facilities can be allowed to develop Health Maintenance-type services. HMO-type services are distinguished by strong gate keeping and contracting arrangements with tertiary facilities.

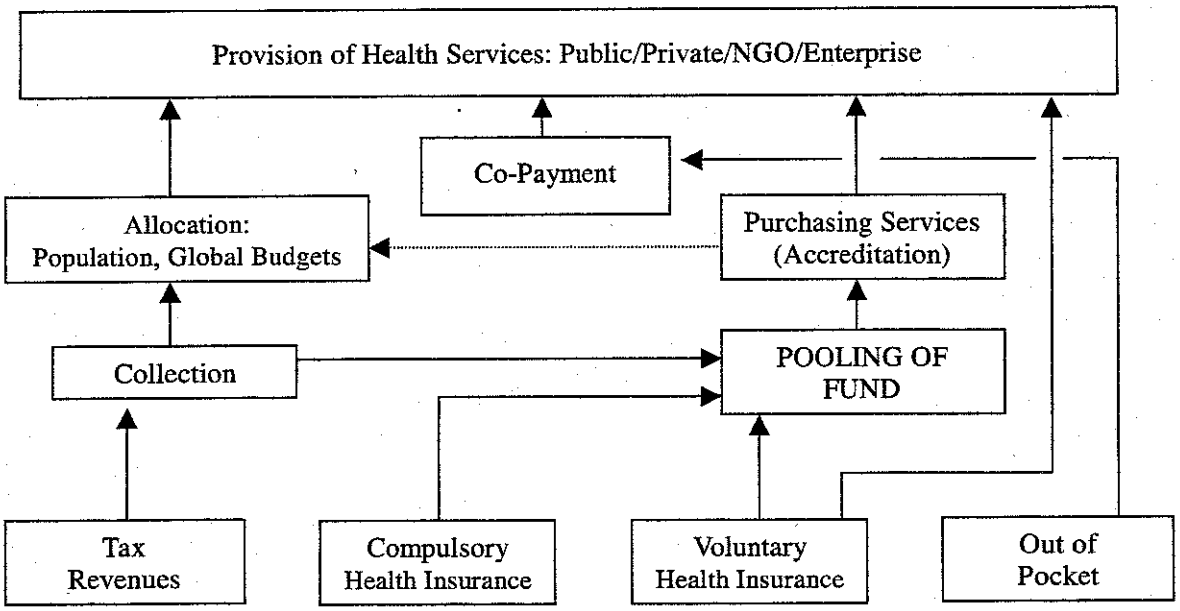


Figure 16.5 A Proposed Health Financing System for Uzbekistan

c. Develop facility-based pooling of out-of-pocket payments. Facilities should not be penalized (by lower subsidies) for increasing revenue sources so long as there is transparency in collection and disbursements. The rationale for this proposal is that it must be shown how facilities will use and manage money from a bigger pool of funds as a result of insurance payments.

d. Adopt a disease classification system and improved information systems for timely and accurate data. Pooling arrangements need information on members (age, sex, and location), disease incidence, etc. for pricing and collection purposes.

e. Legal basis for compulsory health insurance.

f. Gradualism in implementation also implies determining the criteria for coverage and expansion. Ron and Abel Smith (1996) listed out the following criteria:
   - Size of enterprise
   - Geographical area
   - Category of insured persons or of dependents automatically covered
   - Type of benefit

The idea is to gain experience first in collecting and paying benefits under a benefit-based system. Weak administrative systems in rural areas and self-employment in rural areas may require that the geographic spread be increased gradually. The benefit package may be divided into basic, comprehensive or supplemental.

Experiences in neighboring countries in the region show that rapid expansion could lead to inefficiencies and shortages, and this questions the credibility and authority of the insurance institutions. However, slowing the pace too much may also inhibit innovation and dynamism.

2) Compulsory pooling of funds in most cases happens a year or two after the legal base for compulsory insurance is established. It will comprise contributions from:
   - Social funds (pension, unemployment, social welfare)
   - Employers
   - Employees
   - National subsidy as counterpart to regional authorities' paying for poorer groups in its population

New collection mechanisms can be instituted for non-salaried, non-poor groups through Mahallas, business permits registration, etc..

3) A Single Insurance Fund System, with a National Health Insurance Agency (NHIA) responsible for funds collection and premiums pooling will be the most viable system. Premiums from government employees will be deducted at the tax collection levels and remitted to the NHIA. Private employers may directly pay their share and their employees' premiums to the NHIA. Premiums will be paid by social fund bodies to the NHIA.

4) Local budget systems for health facilities should be used under the new provider payment schemes. This will ensure that regional authorities have control over their facilities and resources; it will also ensure that equity considerations are included. The allocation is based on the Ministry of Health's guidelines.

5) The NHIA may contract with facilities to provide services for members. Payments to these providers will come from NHIA, or in the long term, coursed through other purchasing groups.

6) The NHIA is responsible for accreditation of facilities for quality assurance and control. Certification by the Ministry does not guarantee accreditation to the NHI program.

7) Payments to providers will be based on negotiated rates and case payments. Health insurance will complement public budgets and not seek to replace them.

16.2.5 Policy Issues

1) Multiple funding vs. Unified Funding: Will social fund authorities and regional authorities be willing to make contributions for their members' participation? If these funds are not remitted, then the NHI will not be fully universal, nor will it be sustainable.

2) Multiple Funds Holding vs. Single Funds Holding: The proposed system will have the NHIA as the sole repository of funds subject to approved implementation guidelines and audit rules of the Republic. It will establish basic administrative offices in the regions. Multiple funds holding (like a Russia) will limit risk-pooling to a smaller base (regions and/or groups) and defeat the purpose of having a large pool of funds for active purchasing. Multiple funds will also be harder to monitor and make the system subject to mismanagement.

3) NHIA fund vs. Tax Revenues/Budget fund: There is a concern that once government facilities start receiving funds from NHIS, local governments will no longer sustain funding to the health facilities. The expectation is that in the long-run, there will be a re-alignment of local government funds to support primary and preventive

activities, while secondary and tertiary facilities will get an increased share of funding from the NHI A. In the short term, there are certain design aspects that will prevent outright loss of funds to the health sector: a) local authorities will want to invest in their facilities to attract insured members; b) an active accreditation system will require investments from 'owners' of facilities before NHIA funds start flowing; c) strong facility-based governance reforms will ensure proper budgeting and funds allocation; and d) a national health accounts system will show whether the reduction in public budgets is offset by insurance spending.

4) Is there consensus to define benefit limits or develop a 2-benefit system: basic and comprehensive? Defining a basic benefit package will make premiums affordable, and for sustainability reasons, a benefit-based system will introduce a disciplining element through co-payments.

5) Level of contributions. There is a concern that contributions for health insurance will be an added burden on employees. The proposed system is designed in such a way that contributions and benefits are linked. An examination of country comparisons in an earlier presentation (International Comparison paper) showed that insurance premium rates (including social security) ranged from 15 percent (United States) to 42 percent (Germany) in 1998/99. These levels are for higher income countries where benefits are comprehensive. Employees pay approximately one-half of these premiums. Lower income countries with limited benefits have contribution structures not higher than 3.5 percent of salary income, which is further shared between the employer and the employee. NIS and CEE (Newly Independent States and Central and Easter Europe) countries imposed 13-18% of income as levels of contribution (Dixon, Langenbrunner and Mossialos, citing Preker, 2002).

6) Role of the Ministry of Health vis-à-vis that of the NHIA
The NHIA will be a government body under the administrative authority of the Ministry of Health, but remain independent. The Health Minister is the head of NHIA's Executive Committee. The Executive Committee members include representatives from Finance, Regional Authorities, Social Funds, Research Centers, Enterprise Centers, private persons representing members and providers.

This executive committee is responsible for policy formulation, supervision, dispute

and mediation, investments and actuary.

The NHIA is responsible for the following:

a. As the insurer of the NHI system, it handles collection of premiums for certain groups, receives premium collections from other agencies and pays out providers or other authorities serving as fund-holders.
b. Handles administration of all NHI business, guidance and assessment. It may open regional offices if viable, provided the administrative costs for the whole system do not exceed 10-12 percent of the funds collected.
c. Develops accreditation rules for its purchasing of care and works with the quality assurance unit of the Ministry for a single accreditation policy.

16.2.6 Transition Issues

Before the first premiums are made and enrolment activities undertaken, the development stage will require capacities to undertake the following activities:

1) Determine benefit package, if non-comprehensive
2) Develop and understand the price system in health care
3) Determine the premiums and contribution structure
4) Develop accreditation systems
5) Outline basic insurance functions: membership, purchasing care, claims/or and payments, investments, marketing
6) Research health insurance experience in other countries to improve design of the proposed system.

At present, there are limited resources in the country and in the region for these needs. Hence, the transition requires the formation of a Health Financing Unit within the Ministry of Health that will serve as the focal point to steer these activities and ensure that the introductory process for health insurance is linked to other financing reforms. The Core Unit will also ensure that foreign resources tapped for assistance in this endeavor are maximized and that there is adequate technology transfer. More importantly, the Unit will be responsible for building consensus for the reforms. Without this focus, the reforms will be handicapped.

The drafting of the Law on the National Health Insurance Program is a tangible milestone. However, the process that leads to this milestone and what happens after is more important. Consensus building activities and agreement on the basic design will provide the key elements to the Law on National Health Insurance. Subsequent implementation of rules and regulations will provide the 'nuts and bolts' to the system.

16.2.7 Funding Health Reforms

Proposed health sector reforms, health insurance development and subsidies can be funded from a share of taxes that can be introduced specifically to promote health, that is, tobacco and alcohol taxes. Moreover, money raised from structural reforms (sale of some facilities, transformation into self-financing status) can also be utilized. An Executive Order may need to be passed to prevent regional authorities from cutting health budgets during the reform process. Donor support is vital to speed up the reform process.

16.2.8 Concluding Remarks

The evolving health finance system for Uzbekistan will result in some key benefits for Uzbekistan's health system. These include:

1) Coordination of all sources of funding under a common policy framework;
2) Universal coverage for citizens;
3) Less duplication of responsibilities for service provision, resulting from vertically integrated health systems associated with each level of government's administrative structure, through active purchasing of care arrangements;
4) Introduction of an insurance function to the system;
5) Outlining of explicit policies on access by the poor backed by clear financing incentives.

16.2.9 Addendum: A Tale of Two Systems

The proposed system contained in this document takes into account the issues raised above and provides for a single policy framework for reforms, whereby budget reforms and the introduction of a health insurance system is viewed in parallel, as complementary systems, with a single objective – better health security for Uzbekistan. Delays will only make the

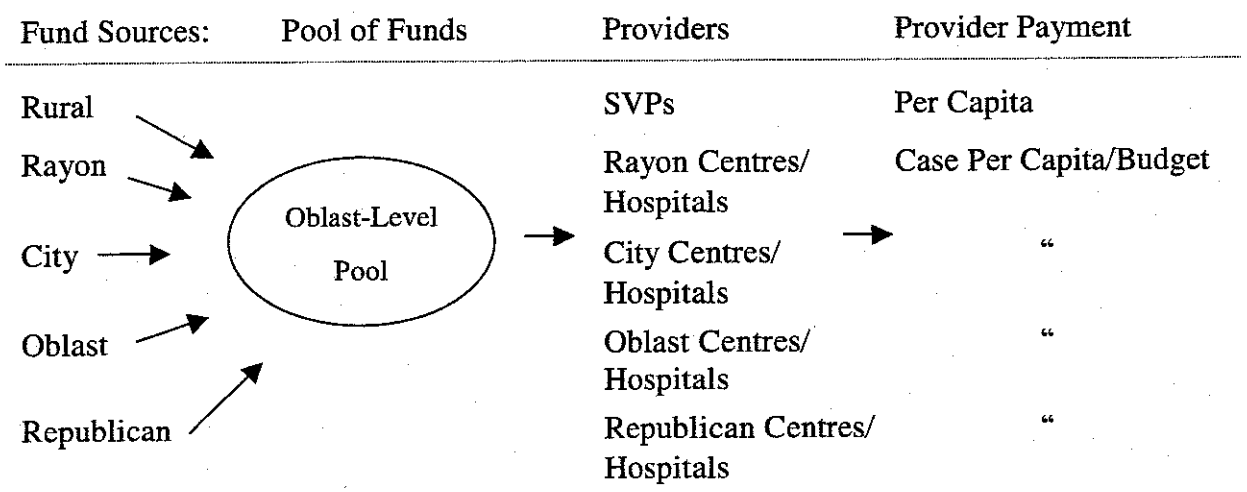
system more expensive in the future, particularly in terms of provider resistance and greater consumer demand. Having a young population may also be favorable in terms of lower utilization. There is no denying that resource allocation decisions of the budget and health insurance system are different.

Table 16.12 Budget and Health Insurance Allocation Decisions

Budget	Health Insurance
1. How much to allocate to the health sector?	1. What services can be covered for beneficiary groups?
2. What will the sharing be across geographic areas?	2. Who will deliver these services?
3. What will the different services get—Primary care, hospitals, medical education?	3. What is the cost of these services? What is the contribution structure?
4. How will the providers get their allocation?	4. How will the providers be paid?
5. How will providers spend their funds across different inputs?	5. Did members get value for their money?

Those who are in favor of pooling but not of insurance see the pooling of funds to occur in terms of budget consolidation. Proponents argue for purchasing to occur under functions 4 and 5 of the budget system (Zdrav Reform, 1999). One can visualize the system as follows:

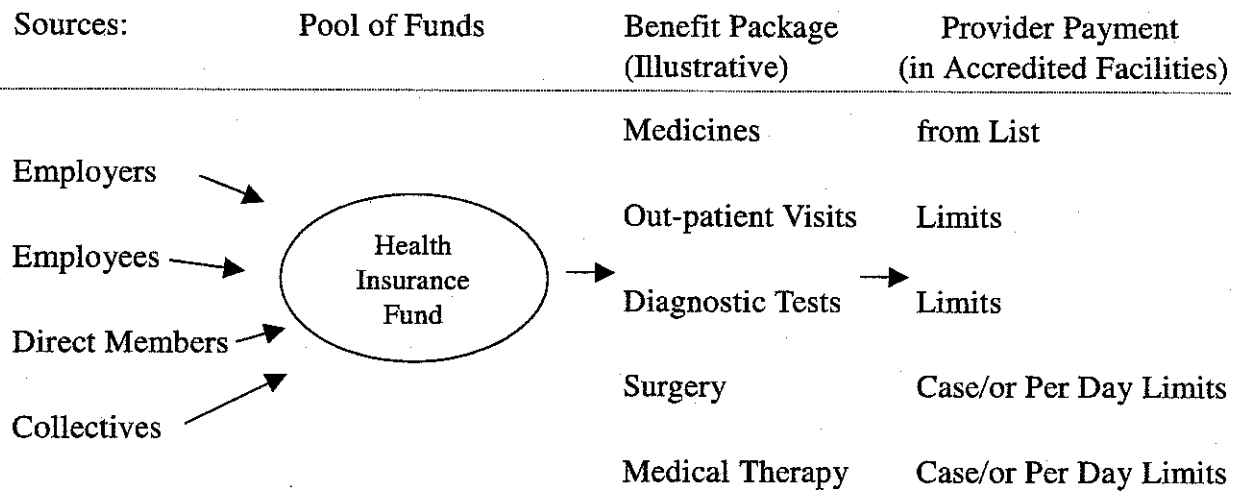
A View of Budget System Reforms



Budget reforms are anchored on structural changes at the provider levels. Certain facilities have to be closed or merged to come up with an efficient delivery system.

Health insurance, proposed to be undertaken under a compulsory system, would pool funds coming from members' contributions. This would expand the pool of funds outside of budget revenue sources. If health insurance increases the funds for facilities, any budget support for the facility maybe released and invested elsewhere.

A View of Health Insurance



The approach proposed in the Master Plan seeks to maximize on the best features of the two systems: equity under budget system and efficiency under health insurance. Building a well-coordinated health financing system in Uzbekistan is the challenge.

16.3 Improvement of Medical Services at Rayon Level

16.3.1 Background and Rationale

As important part of the reform of medical services system in Uzbekistan, the improvement of the medical services system at the Rayon level is necessary. Particularly, the first referral facilities are the most familiar and closest existence to the patients from the standpoint of accessibility, providing medical services such as preventive medicine and early treatment.

SVP (Rural Physician's Point) is the first referral medical services in the Uzbekistan. As a medical facility, it is the first access point for out-patients at the Rayon/rural level. On the other hand, for in-patients, CRH (Central Rayon Hospital) is the first access point at the

Rayon/rural level. Therefore, CRH has a role of strengthening the first- referral- level medical services.

Health I Project by the World Bank is being implemented in three Oblasts (Ferghana, Syrdarya and Navoi) to establish SVPs. This project has achieved in strengthening of rural PHC services; it will be called Health II Project, and expanded into the other Oblasts from 2004. However, several issues still remain to be undertaken: improvement of the preventive medicine and IEC activities to the inhabitants; the strengthening of the management capability of SVP itself; improvement of city type PHC facilities.
CRH is an important medical facility as first referral medical services. It covers approximately 60% of medical treatment of Uzbekistan. In addition, as central medical facilities, CRHs play a lot of functions and roles in the area, such as the technical support to SVP, the procurement of the drug supply, the collection of the medical information and the acceptance of the patients from SVP.

The World Bank has provided the laboratory equipment to the pilot CRHs. ADB plans to develop the mother and child health care programs. However, the influence from the Soviet Union period still remains in CRH, and therefore the existing function and capability of CRH are not always sufficient to the required functions of CRH; to build up the consciousness and capability of the medical personnel, managing and financing capability, quality control of the laboratory test and diagnostic examination, medical information, drug management, condition of the facility and equipment, and operation and maintenance system.

Consequently, for the improvement of the first referral system in rural area, it is important to strengthen CRH, which has a role of providing medical services to the rural areas (Rayon level). The strengthening of rural medical services system at Rayon level will be established through the strong collaboration and cooperation with SVPs and CRH in the designated Rayon. Priority improvement programs herein are to contribute to the improvement of the health situation not only in rural area, but also for entire health condition of Uzbekistan.

16.3.2 Overall Goal

To establish the strengthened rural medical services system at Rayon level so that more

qualified medical services will be realized and health situation in rural areas will improve.

16.3.3 Objectives

To establish overall improvement program for medical services, and to set a qualified model with CRH taking a central role. Results of the program and know-how are to be expanded to the national level.

16.3.4 Project Location

Selection from large scale and small scale Rayons, also giving consideration on whether Health I project is implemented or not.

16.3.5 Target Beneficiaries

Target beneficiaries are inhabitants living in the designated project areas, and medical personnel in CRH and SVPs located in the designated project Rayons. In addition, if the design and know-how attained through the project implementation are to be expanded to other areas, the target beneficiaries will be expanded to the nationwide level.

16.3.6 Project Duration

Three years from 2004 to 2007.

a. Preparation of the pilot program, design of the action plans, provision of equipment: 1 year
b. Implementation of pilot program: 1 year
c. Monitoring, evaluation, analysis of result, analysis, formulation of package model: 1 year

16.3.7 Implementation Agency

The implementation committee organized under the Deputy Minister of Health is the main implementation body at the Republican level. The director of Oblast Health Department and the head of Rayon Health Office are Oblast and Rayon level counterpart for

administration. Director of recipient RCH is an actual implementation agency of this project.

16.3.8 Project Components and Activities

(1) Stage-wise Programs

A stage-wise approach will be applied to the improvement program. The initial stage of the project is to select the pilot study areas and implement the feasibility study, in order to formulate the detailed design for pilot study. Next stage is to implement the improvement programs, obtain the lessons learned (how to implement the pilot study, how to achieve the result successfully) and formulate the package model for other areas. This process will be carried out within the scheme of this proposed project. The expansion of the package model to other areas will be another project such as equipment provision project. The step-wise programs from the initial stage are shown below:

Step 1 : Formulation of pilot model program and detailed action plan for the Rayon level medical services system

a. Implementation of feasibility study on the strengthening of medical services system in the model Rayon, and formulation of improvement programs and action plans for the pilot study areas.

Step 2 : Establishment of management system for PHC Services in Model Rayons

a. Improvement of model Central Rayon Hospital (CRH) by provision of equipment and expert
b. Strengthening of medial services capability in model CRHs
c. Establishment of PHC services system centered on CRH (in cooperation with SVP)
d. Strengthening of coordination and cooperation with higher referral facilities such as Oblast general hospital, specialized hospitals/dispensaries
e. Establishment of system for preventive medicine, early diagnosis and early treatment in model Rayons

Step 3 : Formulation of package model for expansion to nationwide level through the above programs implementation and monitoring results

Step 4 : Expansion of the package model to other Rayons (recommendation of another project)

(2) Logical Framework of the Project

The framework of the proposed project is illustrated below:

Table 16.13 Framework of the Improvement Program of the Medial Services at Rayon Level

Narrative Summary	Indicators	Data Sources	Assumptions
Overall Goal To establish the strengthening rural medical services system in Rayon level for the improvement of qualified medical services and health situation in rural areas	-Disease structure and number of treatments links to reduction of chronic diseases	-RIAC health statistics -Demography & health data	- Stability of government & health reform policy
Objectives Establishment of overall program for the improvement of the rural level qualified model medical services system centered in RCH for the expansion of results and know-how to countrywide	-Rayon health indicators -Rayon disease structure (especially cardiovascular, renal, respiratory and infectious diseases)	-RIAC health statistics -Demography & health data -RCH record	- Stability of needs for rural & national health improvement
Outputs **Step 1** Formulation of pilot model program and detailed action plan for the Rayon level medical services system	- The diagnosis and treatment policy is clear and organization is maintained - The system of the diagnosis and treatment record management is maintained - The diagnosis and treatment ability and results can be understood - Provision of infrastructure (covered field & area)	- F/S Report - Action & detailed design paper	- Stability of government & health reform policy - Needs of rural & national health improvement - Fully support from Uzbekistan side - Appointment of C/Ps properly - Macro-economy growing - Collaboration with donor activities

Narrative Summary	Indicators	Data Sources	Assumptions
Step 2 Establishment of management system for medical services in model Rayons			
a. Strengthening of managing and financing capability of model Rayon and RCH	a. -Improved resource allocation & financing	a. -Record -Financing expenditure sheet	
b. Strengthening of medial services capability in model RCHs	b. -Treatment, lab.test & operation	b. -Record & report, inventory & log	
c. Establishment of Rayon level medical services system centered on the RCH (incorporation with SVP)	c. -Patient referral cases -Guidance to SVP -Guidelines	c -Record -Guidelines	
d. Strengthening of coordination and cooperation with higher referral facilities such as Oblast general hospital, specialized hospitals/dispensaries	d. -Patient referral cases -Emergency cases	d. -Record	
e. Establishment of system for preventive medicine, early diagnosis and early treatment in model Rayons	e. -Guidance to SVP -Guidelines	e. -Record -Guidelines	
Step 3 Formulation of package model for expansion to countywide through the above program implementation and results of monitoring	-Monitoring - Package model	- Report - Program paper	
Activities (See Table 16.14)	**Inputs** (See "(3) Inputs of the Program")		(See Table 16.14) **Preconditions** - Needs of health improvement - No disaster & plague

(2) Project Activities and Components

Project activities and its components during the Pilot Study period are shown in the table below. This is a comprehensive development program, and therefore its activities and components involve all sub-sectors of health care and medical services sector. The main activities are; capacity building of the effective and qualified medical services system in Rayon level; technical transfer to the counterparts in financing, administration and management; formulation of model programs; to obtain lessons learned through the project implementation. The activities are divided into three steps, 1) feasibility study and designing, 2) implementation, and 3) monitoring and package model formulation.

Table 16.14 Activities and Components of the Project

Activity/Component
Step 1 1. To implement the feasibility study on the strengthening of medical service system in model Rayon and formulate the improvement programs and action plans for the pilot study areas 2. To formulate the detailed design of equipment procurement and sanitary facility renovation at CRH 3. To implement the tendering and providing for equipment and renovation
Step 2 a.1. To establish the standard of cost/tariff for medical services and remuneration model a.2 To establish the hospital financing/accounting system a.3 To establish the management of health insurance system in Rayon level (collecting premium, request, payment and management of insurance association) a.4 To improve the retraining and fostering system for managing and financing personnel b.1. To conduct the training and fostering of the medical personnel (physician, nurses, para-medical, laboratory staff, pharmacist, etc.) b.2. To establish the system of medical treatment-outpatient-inpatient-emergency medicine and other supporting services) b.3 To establish the strengthened operation and maintenance capability for facilities and equipment b.4 To establish the strengthened laboratory tests and diagnostic examination b.5 To improve the data arrangement and medical information system b.6. To improve the drug control, procurement system and drug taking record b.7 To remind the medical staffs' conscious change to "medical services for patients" c.1 To establish the strengthened coordination and cooperation with SVP c.2. To prepare the guidelines for medical services and related activities c.3 To establish the supporting system for SVP (medical services, emergency medicine, drug management/procurement, health information, laboratory tests, etc.) d.1 To establish the strengthened coordination and cooperation with higher referral facilities d.3. To strengthen the emergency medical services system ("03" receiving dept., patient transfer system) e.1 To implement IEC system and health promotion at Rayon level e.2. To prepare the guidelines for preventive medicine
Step 3 1. To monitor and evaluate the pilot study implementation 2. To analyze the result and identify the best practices, lessons learned. 3. To formulation the package model for other Rayons (manual/guideline for hospital management, financing, insurance, drug management, health information system, preventive medicine, equipment operation and maintenance, etc., standard equipment list, essential drug list, etc.)
Assumptions : C/Ps and trainees will not leave their work, positions or health sectors

Note : Heading number of each Activities/Components corresponds to Outputs

(3) Inputs of the Program

For the implementation of this program, both the donor and Uzbekistan side will input the following:

1) Donor Side

- Implementation of the feasibility study on the strengthening of medical services system in the model Rayon and formulation of improvement programs and action plans
- Provision of medical equipment for the model Rayons' CRHs (The recommended equipment list for this project is shown in Appendix Table 16.1).
- Provision of equipment for hospital management, health financing, preventive medicine, health education, and medical information
- Technical assistance of hospital management, health financing/insurance, quality control, medical information, operation and maintenance of equipment
- Overseas training for hospital management, financing management

2) Uzbekistan Side

- Appointment of Counterparts
- Arrangement of the Office Space
- Tax exemption for equipment and material procurement for the project implementation
- Organizing the steering and technical committee for the Project

The outline of the project is shown below;

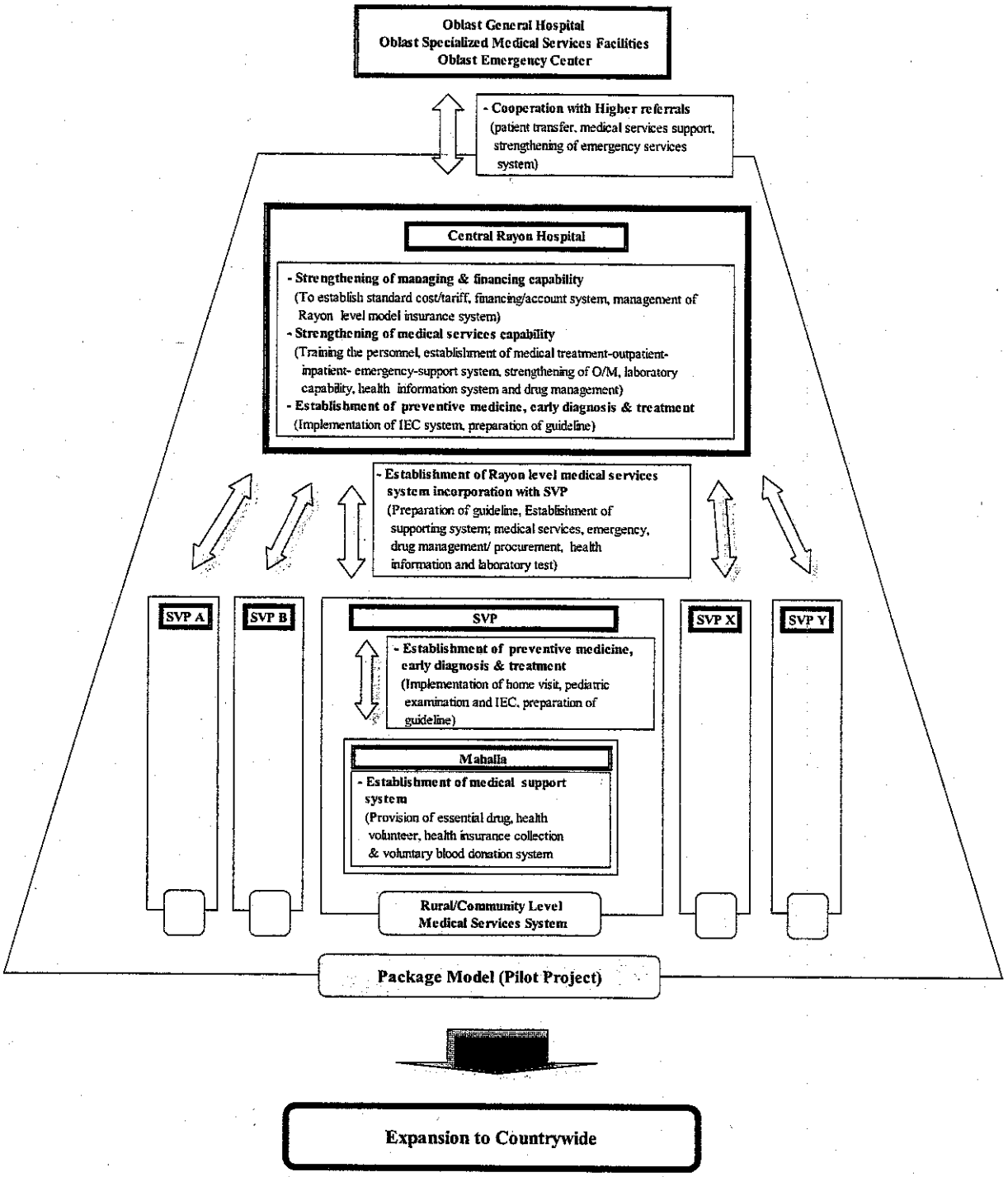


Figure 16.6 Project Image Chart for Rayon Level Medical Services System

(4) Timetable of implementation by the Activities Bundles

The timetable of the program is shown below:

Table 16.15 Timetable of Project Implementation

Activity/Component		1st Year	2nd Year	3rd Year
Step 1				
1.	To implement the feasibility study on the strengthening of medical service system in model Rayon and formulate the improvement programs and action plans for the pilot study areas			
2.	To formulate the detailed design of equipment procurement and sanitary facility renovation at CRH			
3.	To implement the tendering for equipment and renovation			
Step 2				
a.1.	To establish the standard of cost/tariff for medical services and remuneration model			
a.2	To establish the hospital financing/accounting system			
a.3	To establish the management of health insurance system in Rayon level (collecting premium, request, payment and management of insurance association)			
a.4	To improve the retraining and fostering system for managing and financing personnel			
b.1.	To conduct the training and fostering of the medical personnel (physician, nurses, para-medical, laboratory technician, pharmacist, etc.).			
b.2.	To establish the system of medical treatment-outpatient-inpatient-emergency medicine and other supporting services)			
b.3	To establish the strengthening operation and maintain capability for facilities and equipment			
b.4	To establish the strengthening of laboratory tests and diagnostic examination			
b.5	To improve the data arrangement and medical information system			
b.6.	To improve the drug control, procurement system and drug taking record			
b.7	To remind the medical staffs' conscious change to "medical services for patients"			
c.1	To establish the strengthening coordination and cooperation with SVP			
c.2.	To prepare the guidelines for medical services and related activities			
c.3	To establish the supporting system for SVP (medical services, emergency medicine, drug management/procurement, health information, laboratory tests, etc.)			
d.1	To establish the strengthened coordination and cooperation with higher referral facilities			
d.3.	Strengthening of emergency medical services system ("03" receiving dept., patient transfer system)			
e.1	To implement IEC system and health promotion at Rayon level			
e.2.	To prepare the guidelines for preventive medicine			
Step 3				
1.	To monitor and evaluate the pilot study implementation			
2.	To analyze the result and identify the best practices, lessons learned.			
3.	To formulate a package model for other Rayons (manual/guideline for hospital management, financing, insurance, drug management, health information system, preventive medicine, equipment operation and maintenance, etc., standard equipment list, essential drug list, etc.)			
Step 4				
1.	To expand the package model to other Rayons (Recommendation of another project)			

(4) Assignment and Schedule of the Technical Assistance and Consultant

The assignment and schedule of the consultant and/or expert for the feasibility study, technical assistance and model program formulation are shown below:

Table 16.16 Assignment of the Consultant/Expert

Expert/Specialty	1st Year			2nd Year			3rd Year		
1 Project Manager									
2 Hospital Management/Financing									
3 Equipment/Facility Management									
4 Drug Management									
5 Quality Control									
6 Preventive Medicine/PHC									
7 Health Information/Hospital Data Management									
8 Community Participation									
9 Human Resources Development									
10 Coordinator									

16.3.9 Project Management Issues

- This project will directly appoint the Deputy Minister head of project implementation.
- For the project success, collaboration and coordination among Ministries, Oblasts, Rayons and CRHs should be emphasized.
- This project will organize the steering and technical committee that will design, monitor and analyze programs, establish standards and guidelines, and formulate the model package.
- Several donors and international agencies are implementing and/or planning the PHC improvement programs such as Health I & II projects by the World Bank, MCH program by ADB, and DOTS program. Thus, for the effective implementation of the proposed project, it needs to collaborate and make partnerships with these donors and programs.

16.3.10 Other Development Options

The purpose of this project involving the pilot study is to establish the model medical services system at Rayon level, aiming to expanding it to other Rayons. Therefore, it has to consider the implementation of Step 4; distribution of equipment and model package to other Rayons. This M/P recommends the implementation of Step 4 Project following this

Project. The equipment list for this Project and Step 4 Project is shown in appendix Table 16.1.

The project will undertake activities to strengthen SVPs so that the input of the minimum cost will bring about the maximum medical treatment. Accordingly, the system of essential drug will be introduced at every SVP, because in rural areas, inconvenient location of drug stores bears severely on the patients. This program will also involve the drug revolving fund system at community level. The recommended essential drug list is shown in Appendix Table 15.3.

System of Mahalla has its strength in sustaining the preventive medicine for residents, and may be given a viable role in colleting health insurance premium from inhabitants. In this project, it fosters volunteer health worker in Mahalla from the viewpoint of the preventive medicine, and it entrusts the feature of the premium collection to Mahalla.

For above mentioned options, it needs to construct an incentive structure; for example, volunteer health worker may be entitled to the exemption of premium; Mahalla receives incentive reimbursement if the collection of premium from the inhabitants meets the targeted percentage. Moreover, the system of provision and stock of the above-mentioned essential drugs will be provided for Mahalla, and for emergency illness cases, Mahalla office shall be improved in its communication function.

16.3.11 Estimated Project Cost

The total project cost is estimated at approximately US$ 3,298,000 (three million, two hundred and ninety -eight thousand dollars). The break-down of the estimate is listed in the following table.