

HOSPITAL SECTOR REFORM IN UZBEKISTAN – A POLICY NOTE¹

Background

1. *Since the mid-1990s, Uzbekistan has undergone reforms in the health sector focused on restructuring of primary health care in Uzbekistan as well as the establishment of an emergency medical care network.* These were defined in the August 1996 Law on Health Protection and the 1998 presidential decree outlining a new structural framework for the Uzbek health care system and priority areas for health reforms. Recent studies and project supervision visits indicate that the primary care reforms have led to increases in clinical quality and patient satisfaction, and reduced levels of outpatient attendances and inpatient admissions at central rayon hospitals in the rayons undergoing reform. The emergency medical care (EMC) network, consisting of national and oblast level hospitals, EMC departments within central rayon and city hospitals, and the ambulance network, is providing good quality 24/7 services for acute surgical and medical patients free of charge, following a program of upgrading, equipping and training of staff. It has also established referral and support relationships between the rayon, oblast and republic levels.

2. *Reform and development initiatives in at secondary and tertiary care level have been limited to gradual downsizing of sub-national hospitals, with the exception of the emergency medical care network, and expansion of Republican specialized tertiary centers.* There have been gradual policy changes related to the structure and expenditure allocation to hospitals leading to reduction in hospital capacity. Between 1997-2005, the number of rural hospitals was reduced by almost half and the number of urban hospitals by around 20 percent, while overall hospital bed capacity was reduced by almost 50 percent. From 2000-2007, the number of hospital beds per 1000 of population has fallen from 5.3 to 4.8, but this ratio remains high compared both to other LMICs and upper income countries. Over the same period, 135 sub-national hospitals have closed (a 1.3% reduction); sub-national bed numbers reduced by 2,246 (a 1.8% reduction), doctor numbers reduced by 3.8%, and the number of admissions reportedly grew by 30%. At Republican level, over the same period, 5 additional single specialty facilities have been established, bed numbers have increased by 7.4 percent, doctor numbers have increased by 46.6%, and admissions have increased by 56.2%. Emergency medical center admissions over this period increased by 240% at Republican level and 163% at sub-national level.² While some of this growth may represent changes in classification of admissions, it is evidence of the attractiveness of the upgraded, free EMC network. The pattern of bed reductions has been somewhat uneven across regions and facilities. This appears to have led to some variations in access to secondary care across regions. Further incremental bed reductions are planned, which may amount to a further 20% over the next five years, mostly focused on rehabilitation hospitals.

3. *Recent years have seen increases in out-of-pocket payments (both official and informal) for hospital and other health services, which now present a barrier to accessing health services and pharmaceuticals for some patients.* Although budget expenditure on hospitals appears to have increased in real terms, the salaries and benefits budget has taken up a rising share. Lack of budget for maintenance and replacement of buildings and equipment means that most sub-national hospitals are in poor repair, and unable to carry out the range of diagnostic

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² Caveats apply to data on admissions, bed numbers, etc. Inconsistencies are found in the data. Additionally, the site visit undertaken, and site visits reported by previous hospital consultancies note that observed hospital occupancy rates at the time of visits are markedly lower than averages reported by facilities to the MOH. Sydarya, for example, reports data that would imply an occupancy rate of 85%, higher than estimates of around 70% provided by the hospitals visited. During site visits, with the exception of EMC branches, occupancy rates appeared much lower.

and treatment services they were designed for. The combination of low quality and increased user fees has also produced low utilization and occupancy, except in the EMC network and in Republican level hospitals.

The Government's Plans for Hospital Reform and Development

4. Recognizing the concerns summarized above, *the Welfare Improvement Strategy 2008-2010 and the Decree of the President of Uzbekistan (PP-700 as of September 19, 2007)*, “*On main directions on further deepening of reforms and implementation of the State Program on Healthcare Development*” identifies inpatient and specialized care as important areas of focus for the next stage of health sector reforms with the aim of improving the performance of medical establishments. The improvements are intended to improve the quality of secondary care in rayons/cities and make tertiary care available in oblast facilities, to increase access and reduce self-referral and referral to specialized hospitals in Tashkent. The Presidential Decree approves the following main actions:

- a. Structural changes in the organization of the central Ministry of Health (MOH), Oblast Health Departments and Rayon Medical Unions and subordinate health facilities at these levels. These are intended to standardize the organization of health facilities at Oblast and rayon/city level. The changes consolidate hospital facilities in rayons/cities under a single legal entity and management. It is not yet clear what extent of consolidation, if any, of Oblast hospitals and specialist dispensaries is envisaged.
- b. A new set of stand-alone diagnostic centers at Republic and oblast level, subordinate to the Departments for Maternal and Child Health. It is envisaged that these centers will be self-financing commercial operations, charging to recover costs, except for patients from socially protected groups, who will be financed by vouchers. Primary care and rayon/city hospital facilities will refer patients to these centers for diagnosis and advice that is beyond their capacity.³ Capacity building in management and other necessary skills, together with annual attestation, for health system managers and MOH personnel.
- c. Transfer of finance/accounting departments of OHDs and oblast and rayon hospitals into the finance departments at the corresponding level of local administration, in conjunction with bringing OHDs and health facilities into the single Treasury system from 1 January 2008, and making MOF/finance departments responsible for close control over use of budgetary funds for health. This entails allocation a fixed amount of cash to the facility each month, broken down into four input categories (salaries, personnel benefits, capital, non-salary operating expenditure).
- d. Strengthening safety of blood transfusion and blood processing, introducing single-use instruments, and capital upgrading for the blood transfusion facilities and AIDS centers.
- e. Introducing up-to-date regulation of private medical establishments, and regulations for the MOH's licensing and quality control functions.
- f. An investment plan for upgrading rayon medical unions, oblast multi-profile hospitals and multi-profile children's centers, and diagnostic centers. The MOF has budgeted US\$500 million for civil works investment over 2008-2012 for this program, and is seeking finance from development partners/donors for equipment and training costs. The plan has already been formulated, based on a comprehensive inventory, and bottom-up proposals from rayons and oblasts, and

³ The concept for the Centers is not yet formally defined, but current thinking about the Centers differ somewhat from that found in typical stand-alone diagnostic centers in most countries, in that it is envisaged they would not only provide laboratory testing and diagnostic imaging services, but would also have a range of clinical specialists who would provide consultations on diagnosis and would refer patients for treatment. There is therefore a need to safeguard against the risk that these centers could become a new level in the referral chain, further fragmenting care.

reviewed and approved by the Ministry of Economy. At the time of writing was awaiting final approval by the MOF.

- g. Establishment of a specialized company, which could be a joint stock company or a public-private joint venture, to lease and service modern medical equipment to medical establishments.
- h. A training and re-training program for doctors (through clinical residency), and for head doctors and their deputies (on healthcare management).

5. The Government has also introduced some financing and provider payment reforms in four of the 10 Republican Specialized Centers⁴ and will roll out these changes to the rest, and has introduced increased user charging for Oblast hospitals based on earlier health reform decrees. In the 10 Republican Centers, the Government has introduced payment on a “completed case” basis⁵. The Government is gradually reducing its subsidy of the price per case, and user fees are being increased in parallel. Self-financing patients pay fees for service for initial diagnostic tests. For treatment, they pay an advance based on the Government’s “completed case” price, but if the fees for actual services used are less than this price, the difference is refunded to the patient. The Specialized Centers have been given increased financial autonomy as a corollary of this new payment system – they receive budget funds as a single, flexible line item. Fee income is managed outside the Treasury system. Hospitals can use fee income to pay salary supplements to staff, and pay for additional operating costs and minor capital. The original intention was to phase out the budget subsidy for self-financing altogether over a five year period. In practice, the Government has proceeded more slowly, and at a variable pace for different specialist centers. Recognizing that some high cost procedures are unaffordable even for the non-poor, the Government is considering retaining some subsidy for a list of around 100 high cost procedures, such as cardiac surgery. Socially protected groups can receive free care by obtaining a voucher. The quantity of vouchers is equivalent to around 20% of the hospital’s total caseload in the previous year (though there seems to be some variation in this percentage across different hospitals). Vouchers are allocated to the OHDs, who in turn allocate them to rayons, to allocate to patients each month. If there is excess demand for vouchers in any particular month, oblasts can “borrow” from the next month’s voucher allocation. There is also a contingency fund (reported to be 8% for the Republic Specialized Surgical Center) for high priority cases if total demand for vouchers is exceeded.

6. The phasing down of Government subsidies has also occurred in Oblast hospitals (other than emergency medical, children’s and obstetric hospitals and hospitals and dispensaries treating the “socially important diseases”, which provide free care). Official user fees have increased as the subsidy has decreased. In these hospitals too there is a voucher system for the socially protected groups. Vouchers are allocated by rayon-level health facilities. However, oblast hospitals are not paid for voucher patients on a completed case basis. They are allocated a budget based on four input-based expense categories. The budget fully covers their salaries and benefits, and covers around 20% of non-salary operating costs. The Government is considering extending the completed-case based payment to Oblast multi-profile hospitals and increasing self-financing in these hospitals also.

7. The MOH is implementing a program of development of new standards for diagnostic/curative services at each level of care that are intended to modernize practice and increase quality and efficiency. Twenty disease areas have been covered to date. Standards for equipment requirements at each level are also being defined. The Ministry now faces the

⁴ These are mostly single-specialty hospitals providing tertiary care and higher-level secondary care; but also include a Specialized Surgical Center that provides a range of surgical specialties. All are located in Tashkent.

⁵ There is a single payment per case – the same price for all cases - in a given hospital (unlike the case-based payment which has been developed for the Ferghana hospital provider payment reform pilot, which is a simplified system of Diagnostic Related Groups (DRGs)). In the Specialized Centers, price per case is based on actual cost and number of cases in each hospital in the previous month.

challenge of developing a strategy to changing clinical and managerial practice in hospitals to bring them into line with the new standards.

Donor-Supported Hospital Reform Initiatives

8. The framework the main development partners have adopted for recommending system reform in Uzbekistan is a “purchaser-provider split”, in which Rayon/City Health Departments act as purchasers of primary care; OHDs act as purchasers of hospital care, and the MOH acts as the purchaser for republican specialized services. Under this framework, providers would be paid for services or outputs and have a degree of financial and managerial autonomy over management of budget and inputs. Patients would have some choice. Money would follow patients. The primary care reforms adopted were consistent with this framework until end of 2007. The Zdrav-Plus project has supported development of a pilot for implementing this framework for hospital services, beginning in Ferghana. It has supported development of Health Management Information Systems (HMIS) to collect information on outputs, costs and some quality indicators. Using this information, it has developed a proposal to introduce case-based payment based on a simplified taxonomy of diagnostic-related groups. The MOH and MOF have agreed in principle, and recognize the need for hospital payment reforms as part of a comprehensive approach to create incentives for improved productivity.

9. Under the ongoing World Bank-support Health Project, initially it was agreed that the legal basis for rural and urban hospital payment reform would be put in place by March 15, 2005. This time frame proved unrealistic, and in the Project mid-term review, revised milestones were agreed for piloting payment reform in Ferghana. The hospital information systems and data collection that underpins payment reform is now to be rolled out to all central rayon hospitals (CRHs) in Ferghana by January 1, 2009. The required technical work for determining the case groups and case payment rates for the Ferghana pilot is due to be completed by September 30, 2008, and the MOH and other relevant governmental agencies are due to issue the needed approvals to start piloting case-based payment in central rayon hospitals no later than January 1, 2009 in Ferghana and July 1, 2009 in Karakalpakstan. However, some issues need to be worked through between the MOH and MOF in order to put in place implementing regulations/guidelines for the provider payment reform. The main practical issue to be addressed is the implications of the case base payment system for the way in which the new Treasury system operates at oblast and rayon level. The initial formulation of the Treasury reforms places an unrealistic burden on OFD and RFD personnel in reviewing and responding to any requests for the reallocations needed to manage the normal month-to-month variation in hospital expenditures. There is a need to revise the regulations and allocation of roles and responsibilities so the OHDs become responsible for pooling and managing risks arising from variation in utilization of hospital services. The Bank is providing technical advice currently on the Treasury reforms, and could facilitate resolution of the issues.

Key Reform Issues in the Hospital Sector and Options for Addressing Them

A. Sector Organization: Fragmentation

10. *Uzbekistan has a large and fragmented network of hospitals and specialist clinics, characterized by multiple vertical programs and many single-specialty facilities. There is lack of clarity regarding the specific roles and linkages between the numerous hospitals and specialized care facilities.* Like most countries in the former Soviet Union, Uzbekistan inherited a huge, outdated, and expensive specialized inpatient-treatment network. Despite the successful primary health care (PHC) reforms, a large share of public expenditure. Sixty five percent of the national health budget continues to be spent on hospitals.⁶ At sub-national level, rayon and city

⁶ Health Care Systems in Transition: Uzbekistan, European Observatory on Health Systems and Policies, March 2007.

hospitals account for around 70 percent of hospital expenditure (up from 66% in 2000, in spite of hospital closures and bed reductions) and oblast hospitals around 30 percent (down from 34% in 2000, as budget cuts have been implemented in parallel with increases in user fees). The gradual reduction in hospital capacity since independence has not been part of a planned, comprehensive package (as was the case in primary care reform) and therefore with most physical structure and staffing remaining unchanged, there have been limited savings and efficiency gains. Most closures occurred in small multi-profile rural facilities: few single specialty facilities or specialized dispensaries have closed. Some of the bed capacity reductions have taken place by closing off rooms within existing facilities, without resulting in closure of whole buildings or facilities, which achieves relatively little cost saving.

11. At the republican level there are tertiary specialty hospitals which have their affiliates in the oblasts (regions/provinces). The emergency care network operates a republican emergency medical center (EMC) in the capital city, and a subordinate network of EMCs in oblasts and EMC departments within city and rayon hospitals. Maternity hospitals and children's hospitals are mostly separate from other hospitals and are subordinate to a separate deputy Minister at national level and separate director at oblast level. The San-Epi system is another parallel vertically managed service, with its own laboratories and clinics/hospitals for infectious diseases such as HIV/AIDS. Some major industries also operate their own hospitals and clinics for their employees, retirees and their dependants. In oblasts and rayons (districts) and cities, there is a wide variety of secondary care hospitals and specialist dispensaries, with the structural organization differing from place to place. In addition, with the juxtaposition of specialty and multi-profile hospitals – most of them physically and administratively separated, duplication and overlap of services is widespread. A coordinated institutional structure – with rational physical and administrative/functional integration and clear definition of the corresponding roles and responsibilities would be able to bring better synergy and efficiency for the inpatient service delivery system on the one hand, and offer the population with better access to these services on the other hand.

Case Study: Syrdarya Oblast (population around 690,000; 2 hours' drive from Tashkent) has an EMC hospital in the oblast capital, a multi-profile (general) oblast hospital, a children's hospital, 15 other multi-profile hospitals (mostly central rayon hospitals), 5 single specialty hospitals (including an ophthalmology hospital, some rayon maternity hospitals and a rehabilitation/spa hospital), and 11 specialist dispensaries, including some with inpatient beds for endocrinology, oncology, cardiology, psychiatry, narcology, TB, venereology/dermatology, Sanitary and Epidemiological Services, and outpatient dispensaries for youth and for sports medicine. Total bed numbers at 5.8 per 1000 are clearly excessive, fragmentation across multiple buildings and locations (many with unused rooms and underemployed staff, following minor past bed reductions), is extremely inefficient. Many patients from Syrdarya self-refer or are referred to services in Tashkent, because of low patient-perceived quality and lack of diagnostic equipment in many of the local hospitals. The Oblast's plans for hospital development under Presidential Decree PP-700 appear to entail further fragmentation at oblast level: a separate oblast maternity hospital (in place of a maternity department integrated in the oblast multi-profile hospital) and a stand-alone oblast diagnostic center would be established. The oblast hospitals plan to upgrade their own diagnostic equipment – not to use the planned new diagnostic center. A population of this size and distance from the capital in an EC country with a modern hospital system would usually be served by 1-2 multi-profile hospitals, combining emergency and non-acute admissions, sometimes supplemented by community hospitals for normal obstetrics and step-down care, and nursing homes for the elderly.

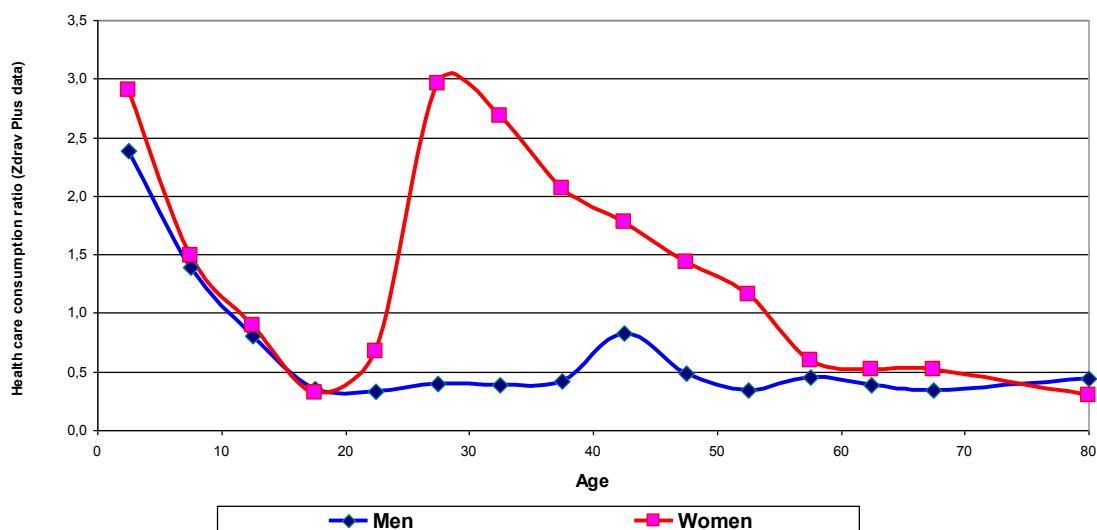
12. The fragmented specialty structure inherited from the former USSR dates from the 1960-1980's. It does not reflect the current pattern of disease and modern treatment methods.⁷

⁷ For example, Endocrinology is organized as a separate vertical network and is free, because it has "Socially Important Disease" status. This status derives mainly from a history of high prevalence of iodine deficiency diseases, which are now known to be best addressed by nutrition interventions in the community – such as food fortification. Diabetes is also an important endocrine disorder in Uzbekistan, but would be best managed at primary care level, with specialist support located in multi-profile hospitals, because many diabetic patients also need preventive and treatment services from a range of other specialists, such as ophthalmologists, urologists, and cardiologists.

Additionally, this service configuration is very inefficient: substantial economies could be achieved in utilities, maintenance, clinical and non-clinical support services, transport and communications through consolidation of sites and buildings. In some cases, the fragmented configuration is likely to be unsafe, based on evidence from elsewhere.⁸ The fragmented structure makes it difficult for self-referring patients to find their way to the right care, and so adds to the importance of having well developed referral guidelines and coordination of referral by the primary care systems. However, the extreme fragmentation and regional/local variability in service structures also makes it very complex and difficult to develop referral guidelines – each oblast would require special study.

13. One of the major adverse effects of the current fragmentation for healthcare outcomes is a lack of institutional or managerial focus for the prevention and management of chronic illness and non-acute services for middle-aged and older people, and lack of coordination of services for patients with multi-system disease – mostly non-communicable diseases (NCDs). Care for these conditions often requires occasional hospital admissions, periodic specialist outpatient consultations and good coordination with primary care. Previous sector work undertaken by the Bank (see Figure 1 below) has highlighted that utilization and expenditure on hospital services is unusually low for middle-aged and elderly people in Uzbekistan – whereas this population group is usually the largest user of secondary and tertiary care in middle and upper income countries with reasonable levels of human development. The reasons for the very low utilization by this age group need to be explored, but the fragmented structure very likely is a significant factor. A “typical” older patient with chronic illness or multi-system disease might suffer one or more of the following: high blood pressure, heart disease, type-2 diabetes, arthritis, Parkinson’s disease, cerebrovascular disease, chronic respiratory disease, prostate disease for men or gynecological or breast cancers for women, among other conditions. In Uzbekistan, they would need to visit 6 - 7 different dispensaries or hospitals for diagnosis and treatment of these conditions at Oblast level; in many of these facilities they would face user fees; many of the facilities for these conditions are run-down, ill-equipped and financially unsustainable. Most of these single specialty facilities are outside the scope of investment under Presidential Decree PP-700.

Figure 1: Consumption of Medical Care in Uzbekistan by Age and Gender



Source: Edward Frid and Ilkhom Maksudov, *Per Capita Financing Study*, WB, 2005

⁸ For example, perinatal services are often in separate hospitals and on separate sites from obstetric services, leading to a need to transfer very vulnerable babies between facilities which leads to increased risk of death and disability.

14. Over the last decade, several reports have been commissioned by development partners and projects related to the need for rationalization of hospital services in Uzbekistan.⁹ All of the concerns about hospital configuration summarized above have been made in these reports in some detail, backed up by specific studies and international. All of the reports have made similar recommendations - to consolidate management of the separate vertical systems at oblast level, and to consolidate hospital services at Oblast and rayon/city level into multi-profile general hospitals, combining emergency and non-acute admissions¹⁰. None of these reports has proved to be an acceptable basis for engagement of development partners with the Government and health authorities in the reform and development of the hospital sector in Uzbekistan.

15. **A Possible Alternative Approach:** A recent initiative to develop an improvement program for the Navoi health care system, led by the MOH with support from JICA, may represent an alternative that is better able to engage the support of doctors and patients for reform.¹¹ The process that led Navoi improvement program starts with a focus on the goals of reducing mortality from non-communicable disease (NCDs), rather than a focus on facility rationalization *per se*. The improvement plan addresses the whole spectrum of health services needed to address NCDs – from disease prevention and health promotion through diagnosis and treatment and management of chronic conditions at the appropriate level of healthcare. This approach naturally leads to a focus on coordination of care for patients based on standardized diagnostic and treatment processes, and coordination of service delivery among different sub-specialties. Investment in upgrading facilities to implement the program inevitably has to be consolidated, so as to achieve the best results within a constrained budget. The improvement program is designed to conform to the terms of the Presidential Decree PP-700, but also proposes some supplementary actions to optimize coordination and merge a number of specialist dispensaries into the general oblast and rayon hospitals. However, there is no intention to consolidate the facilities for “socially important diseases” or the separate industry-owned hospital in the oblast. The improvement program’s focus on health care outcomes and quality of services for chronic disease management could provide a more acceptable starting point for doctors, patients and local administrations in discussion of hospital configuration and consolidation in other regions. Though the World Bank’s future investment support is likely to focus on priority needs in CRHs, it would make sense to plan for a whole oblast at a time, so that roles and relationships of facilities in neighboring rayons and of oblast and rayon facilities can be taken into account in planning for a CRH. Nonetheless, if the outcome orientated approach and focus on non-communicable disease used in Navoi is indeed accepted by the Government and oblast authorities, it may be a useful precedent for the World Bank to follow for other regions. However, the Government’s timeframe for going ahead with investment has already begun, so this type of exercise would need to be carried out very soon.

16. **Complementary Measures to Consider:** It may be helpful to complement the kind of planning and assessment done in Navoi with international technical expert advice and training in contemporary hospital functional planning and facilities design. The types of hospital designed inherited from the USSR do not make efficient use of space and site, and are not designed for optimal organization of patient diagnosis and care.

B. Financing of Health Services: Budget Allocation, User Fees and Financial Protection

17. *Expenditure on hospitals accounts for around two thirds of total public expenditure on health (as of 2005), and sub-national expenditure reportedly accounts for over 85% of this.* In

⁹ Zdrav-Plus reports of 1998-1998, JICA-supported Masterplan for the health system, Health-2-supported rationalization plan by Maxwell-Stamp for three pilot oblasts.

¹⁰ Though the reports note the need for a longer transition to address various legal, clinical and social issues in the case of some specialist hospitals, such as those for infectious disease, TB, psychiatry and narcology.

¹¹ *Cite final report when available.*

2005, public expenditure on oblast, rayon and city hospitals amounted to around 230 billion Soums (equivalent to US\$207 million, at the official exchange rate of 1112.94 Soums to the US\$), out of a total health budget of 378 billion Soums. (These figures may exclude expenditure on parallel public health systems for security services, and some government owned industries.) In US dollar terms, budget allocations for sub-national hospitals have been growing at a little under 20% per annum on average from 2000 to 2007 (using parallel exchange rate for 2000, and official exchange rate for 2007), and is projected to increase by 14% in 2008. Expenditure by sub-national hospitals (financed from private revenues as well as budget funds from oblast and rayon/city budgets) has been growing at similar rates. With this growth and the reduction in bed numbers, total hospital expenditure per hospital bed at sub-national level has grown by almost 3.8 times in US dollar terms between 2000 and 2007, while sub-national hospital expenditure per inpatient admission has grown by around 2.8 times, and sub-national hospital expenditure per capita has grown by around 3.5 times. It is not clear that this real growth in expenditure in relation to output and population has translated into improved quality, with the exception of the improvement in the Emergency Medical Care network at oblast and CRH level.

18. ***Recognizing the existence of informal payment for hospital services, the government has formalized co-financing for a number of hospital services. However, there may be problems with affordability of these arrangements and transparency and accountability remains a concern.*** A recent household survey in two cities and two rural areas found households on average were spending from 50,000 to 135,000 Soums annually on health services. From 35-53% of households surveyed agreed that people can receive quality medical assistance only with the help of bribes or connections. Thirty percent of city households and 9% of rural households face problems with being asked to pay to receive primary care. Seventy four percent of respondents did not know on the whole which health services are officially chargeable and which are unchargeable. Six percent of households did not buy all of the medicines they were prescribed at primary care, and of those who did not utilize services, 11% did not have enough money to complete the recommended course of treatment.¹² It is likely that financial barriers to access to hospital care – especially at Oblast and Republican level where higher user fees have been instituted - would be higher than these reported for primary care. Patients are often also unaware of how much they need to pay for each service. Price lists are not displayed at hospitals in a conspicuous manner, nor are clients provided with proper documentation on the payments they make. Where patients are given prescriptions to fill in pharmacies outside the hospital, it is difficult for them to know whether the drug or an alternative medicine for their condition should be available free of charge in the hospital. Control and reporting requirements for self-generated funds have not yet been developed and appear to be weak. A transparent mechanism to handle co-payments for hospital services needs be developed to improve accountability and transparency.

19. ***Current mechanisms for protecting patients from unaffordable and potentially catastrophic health care costs are an increasingly complex mix*** of free facilities or free departments within facilities, free procedures, and free care for socially protected population categories. ***Some patients with limited means or high total health care costs may fall between the cracks*** in these policies. Others may be unaware of the protection available – for example, many people who self-refer to oblast or republican specialized hospitals may be unaware of the voucher system for obtaining free care, even if they are eligible for this assistance. Free coverage for secondary and tertiary care has largely been limited to predefined “socially protected” population groups (people with disabilities, children, and war veterans) and to defined conditions (emergency medical care, obstetric care, and services for the “socially important diseases” - endocrinology, tuberculosis, oncology, HIV/AIDS and venereology, psychiatry and narcology). Additionally, user charging at rayon hospitals is very limited. However, the

¹² *Primary Health Care Service Quality Delivery Survey: Draft Report on the Household Survey*, World Bank, October 2007. Note that while the focus of the survey was on primary care, some questions were framed in general terms, applicable to all health services.

protected population groups do not include all of the poor and include some non-poor. And the free services and hospitals do not include all of the high-cost care and high cumulative costs of on-going care for chronic conditions, which are likely to be unaffordable and potentially impoverishing for the near-poor. Additionally, the current system of financial protection leads to some inefficiencies in organization and utilization of health facilities. The detailed regulations regarding self-financing in Uzbekistan generally require hospitals to operate separate facilities or separate departments for self-paying patients from those for free care. This is one of the barriers to facilities rationalization. Free, higher quality emergency care for all has produced benefits, but because of the deficiencies in other services, has produced some unintended effects. Patients are often redirected from other levels of care to the emergency services or may seek admission there for non-emergency conditions, which may not be the most appropriate or efficient option. Voluntary health insurance does not yet account for a significant share of health funding in Uzbekistan, but its volume is growing rapidly and could help fill the gap in risk pooling and financial protection not otherwise covered. However this might further accentuate income-related differentials in access. A law on insurance is being developed. The Government envisages that in the short to medium term, insurance will be confined to voluntary, private insurance. ***The Government's future policy intentions for publicly financial protection for health care costs are uncertain.***

20. ***The Government has pursued a policy of increases in official user fees or “self-financing”, alongside offsetting reductions in budget provision for non-salary operating costs in Republican hospitals and many Oblast hospitals in recent years.*** City and oblast hospitals have self-financing beds. User fees are projected to amount to an average of 18% of revenue in 2008 for oblast hospitals (compared to an average of 1.4% in 2000). Republican Specialist Centers (tertiary level hospitals) now obtain up to around 65% of revenue from user fees, and have a target of 80%. By contrast, rayon hospitals collect little user revenue (projected to be a little under 1% in 2008, a level that is approximately unchanged since 2000). Budget funds for oblast hospital now cover little more than the costs of staff salaries and benefits, following budget reductions that offset increases in user fees. (See Table 1 below).

21. **Actions to Improve the System of Financial Protection for Hospital Services:** There is uncertainty in health financing policy in Uzbekistan, regarding the future of public financing for hospital services, and the future system of financial protection from the costs of hospital care. The existing voucher system for protecting socially vulnerable groups could provide a starting point for developing a system of financial protection for the poor. But in addition, there is a need for more comprehensive and systematic protection from catastrophic costs for the non-poor. Catastrophic costs can arise either from high cost procedures/episodes of hospital care, or from the cumulative effect of ongoing substantial health expenditures for chronic conditions. In the short term, the voucher system could be subject of awareness-raising interventions for primary care doctors, patients and communities. The voucher system could also be complemented by development of referral guidelines for SVPs and rayon/city hospitals (so it could also serve as an intervention point for strengthening the referral system). Over time, it may be possible to review the categories, criteria and allocation system for the vouchers to refine and simplify the system, ensure it covers all of those who need financial assistance for hospital care, and increase the transparency of the basis for allocating vouchers. It seems particularly important to look into the scope for the voucher system to cover older people more effectively. Other World Bank sector work¹³ has identified that relatively few older people (compared to numbers of working age population) apply for or are granted disability status (which is one of the main criteria for vouchers), even where their level of functional disability suggests they could qualify. However, they are likely to be among the groups most in need of financial protection for hospital care.

¹³ Cem Mete, Ed., *Economic Implications of Chronic Illness and Disability in Eastern Europe and Former Soviet Union*, Chapter 2; World Bank, 2008

22. Studies to investigate the extent to which households are experiencing catastrophic health care costs arising from hospital treatment, and the reasons for this could help to provide a basis for revising existing financial protection methods.¹⁴ Some existing LSMS surveys and studies could provide part of the data needed for this work. It would also be useful to commission research into the causes of the unusually low utilization of specialized care by middle aged and older people: user charges may be part of the reason, but other factors may also be important. Based on this kind of information, it may be possible to simplify and streamline existing systems of financial protection and/or undertake information interventions to inform primary care doctors and patients. Additionally, there could be potential efficiency gains achieved by reviewing the existing regulations that lead to separation of hospitals or hospital wards for self-financing patients from those for free care/voucher patients.

C. Institutional and Governance Environment

23. *The current inpatient care system is input-intensive, has almost no incentive for efficient resource use and many impediments to improvement in efficiency, quality and equity of access.* Marginal reductions in the average lengths of stay (ALOS) in inpatient facilities have been achieved. Between 2000 and 2007, ALOS reduced from 13.7 to 9.4 days for Republican facilities, and from a range of 10.2-13.5 to a range of 8.3-11.0 in sub-national facilities. However, these levels are still high compared to international standards. Doctor and nurse numbers per bed have increased in Republican facilities over this period, and reduced only marginally in sub-national facilities. As staff salary and benefit costs as a share of total health expenditure have increased, this has crowded out spending on maintenance and supplies, to the detriment of quality. Oblast hospitals now rely on user fee revenue to finance over 80% of their non-salary operating costs, on average. (See Table 1.) Rayon hospitals appear to have simply cut back on non-salary operating expenditure, because they are not able to generate much official user fee income. In these hospitals, apart from the EMC departments, the level of care available as a result is now too limited for hospital admission to be of much benefit to patients. Funding constraints have led to unavailability of essential drugs in many hospitals. Patients increasingly are sent to fill hospital prescriptions at private pharmacies, paying out of pocket.

**Table 1: Shares of total hospital expenditure for major input categories;
Salaries+benefits expenditure as a share of revenue from the government budget**

Input shares of spending; personnel costs share of budget revenue (%)	2000	2005	2007	2008 (projected)
<i>Oblast hospitals</i>				
Salaries & benefits	51%	52%	73%	78%
Capital (1)	1.4%	3.2%	2.8%	1.7%
Non-salary operating costs	40%	43%	23%	20%
Salaries & benefits as share of budget revenue	54%	69%	88%	96%
<i>Rayon/city hospitals</i>				
Salaries & benefits	67%	73%	82%	85%
Capital	2.1%	0.7%	-	0.2%
Non-salary operating costs	32%	25.8%	14.7%	15%
Salaries & benefits as share of budget revenue	64%	74%	80%	82%

¹⁴ E.g. it would be helpful to know if patients are experiencing unaffordable costs because they lack information about existing schemes such as vouchers, or eligibility for disability status; because they are not in disease/population categories covered by existing protection methods; or because they are paying informal payments or purchases of drugs and supplies outside the hospital.

(1) Note: most capital expenditure is budgeted and allocated centrally or financed off-budget by development projects. However, except for EMC branches and some specialized centers, there has not been a major investment program for sub-national hospitals over this period.

24. Except for Republican Specialized Centers, ***hospitals have little autonomy over budget allocation, human resource management or infrastructure configuration/capital expenditure.*** Previous flexibility for the hospital to vire funds between input categories (within a 15% limit) has recently been eliminated under the regulations for the new Treasury system. Hospitals now have difficulty managing the usual month-to-month variation in demand and costs that occurs in hospitals due to changing levels of emergency admissions and case-mix, and are forced to resort to informal coping mechanisms (such as informal supplier credit). Virement within the overall budget ceiling requires prior authorization by over-burdened oblast or rayon finance department staff without the level of sector knowledge needed to pool or manage risks within hospital expenditure, and this leads to bottlenecks. Previous provision for hospitals to retain savings of up to 5% in a development fund and use this flexibly to meet need or reward performance has been rendered ineffective as an incentive by the new Treasury regulations, which allocate this fund in fixed monthly cash disbursements regardless of performance. Hospitals have flexibility over use of retained user fee income and can use it for further development of facilities as well as for paying bonuses to reward hospital staff performance. CRHs, lacking significant user fee income, have been particularly hard hit by the changes in the Treasury system.

25. ***Resource allocation and payment methods are based on input-based norms (bed and staff numbers) and reflect ad hoc changes to capacity, resulting in geographic inequity and perverse incentives for efficiency improvement.*** Reform of resource allocation and provider payment systems to a population and output-based method can trigger efficiency improvement. The Government has adopted this approach successfully for primary care, and now needs to move these reforms to the next level in the hospitals sector. Introduction of completed case payment for some Republican Specialized Centers, alongside a voucher system for protecting the socially vulnerable groups, has been a first step in creating greater incentives for efficiency than the previous input-based system. Implementation of the case-based hospital payment system developed for CRHs will be piloted in Ferghana and Karakalpakstan CRHs, but requires some intensive, detailed work over the next six to nine months, as discussed in paragraph 9. Over time, it would be beneficial to refine the completed case payment method for tertiary facilities to create greater incentives for efficiency, develop the voucher system into the basis for better referral systems and patient choice. These developments could focus on two areas where there is potential to achieve more impact. Firstly, because the existing completed case payment system pays a unique price to each hospital based on its historic cost, it does not use either actual or benchmark price competition across hospitals as a lever for efficiency. Secondly, for non-voucher patients, there is a need to develop more comprehensive financial protection from high costs of healthcare, and to introduce levers for management of clinical appropriateness, to prevent profit-driven excessive levels of intervention.

26. A key barrier to reforming the hospital system is the ***fragmentation and overlap of responsibility for planning services.*** Currently, the local administration prepares and executes budgets and delivers public services. Each rayon/city administration is responsible for its primary care centers (SVPs), central rayon hospitals and polyclinics. As health planning is delegated to this lowest administration level with little coordination or oversight at the oblast level, there is no institutional structure for dealing with cross-jurisdictional issues, and little incentive for a rayon to consider the existence of facilities in the neighboring rayons which may be sufficient to provide services for some of its population when making planning decisions. Duplication of services, and lack of development of referral relationships results. But as in many countries where decentralization is recent, the central government also retains substantial involvement in planning and execution of major capital expenditure, in a process that is not does not integrate capital planning with costing and budgeting for the recurrent costs of new or upgraded facilities and equipment.

27. The systems for oversight and accountability for the hospital system are characterized by: (i) somewhat *unclear lines of accountability* between central and local administration following decentralization, (ii) a *focus on inputs with little focus on results*, and (iii) reliance on *vertical, technical routes for oversight*, with limited patient choice or voice. ***The role of the Oblast Health Department (OHD) needs be strengthened to equip them for effective oversight of the performance of the local health system.*** If the Government in future does decide to develop the purchaser-provider split, OHD management capacity would need to be strengthened to prepare them for new responsibilities for contracting hospitals, pooling and allocating health resources, and managing utilization control under the case-based payments system. Some of the financial capacity OHDs have recently lost would need to be rebuilt. Even if it takes some time for the Government to implement this new model, in order to drive improvement in performance, OHDs will need capacity to monitor and carry out comparative analysis of performance. This in turn will call for trained staff, investment in equipment and processes to collect and use data, and regular inspection/assessment/accreditation of health care providers.

28. ***Health Management Information Systems need to be developed to assist in better planning and management of resources.*** Monitoring/information systems for health service outputs, quality indicators and finances need to be developed in all oblasts. This is vital if OHDs become “purchasers” and use case-based payment methods. But already, in order to pursue performance improvement within the existing system, there needs to be an intensive effort to update the Health Management Information Systems at the hospitals, not only with modern equipment, but also with assistance to rationalize and simplify information collection and analysis, and train staff and promote use of information for planning and management. Automation of the existing hospital statistics system through a new hospital database is currently being piloted in Ferghana Oblast and should be relatively easy to scale-up.

29. The Government’s hospital reform initiatives to date at the Republican level have included elements of institutional and governance reforms based on the principle of a purchaser-provider split, associated with increased provider autonomy and hospital payment reform. The challenge now is to extend these incremental reforms to the oblast and CRH levels. There seem to be several issues behind the length of time it is taking for the Government to pursue the purchaser-provider split and case-based payment pilots at sub-national level. Firstly, as noted above, in bringing health facilities into the single Treasury system, the Government has removed the role of the OHD and rayon/city health department in preparing the budget and overseeing in-year re-allocations (a key function of any “purchaser”), and has reduced the financial autonomy of oblast and rayon health care providers, and reduced their incentives to make efficiency gains.¹⁵ It is possible to implement a Treasury system in a way that is consistent with the purchaser/provider framework, but this will require some detailed work involving MOF, MOH, which may benefit from OFD and OHD input. Secondly, the MOF and MOH see a need to develop standards for hospitals and implement a standardized organization of the hospitals network *before* introducing case-based payment. The underlying concern here may be that the current service configuration is likely to lead to a wide range of costs for a given service in different parts of the country, which creates transition issues for implementation of payment system that pays a standardized price per case to all providers. However, standards revision and payment reform can go ahead in parallel, and can be expected to be mutually supportive. Additionally, some OHDs are concerned about how they will manage risk and uncertainty of expenditure under a case-based payment system, and perceive the existing system (in which budget is allocated primarily based on bed numbers) as easier to manage and control. It is important to recognize that this risk and uncertainty is inherent in health and hospital systems. Input based expenditure management systems that ignore this risk invariably produce pressures

¹⁵ This affects primary care providers as well as hospitals. Per capita financing of primary care providers is now used only to set a budget envelope. Within this envelope, primary care providers are now paid on the basis of fixed input allocations.

that are managed in other, less desirable ways – for example by charging informal fees to patients, referring patients to private pharmacies and medical suppliers, using informal private financing mechanisms that breach other MOF regulations, or in worst case, denying care to sick patients who cannot pay.

30. As part of a comprehensive approach to hospital reform, it would be realistic for the Government to strengthen institutional and governance arrangements to drive performance improvement by building incrementally on the hospital reform initiatives the Government has already initiated at Republican level, the planned case based payment pilots at CRH level, and the MOH's new hospitals standards development initiative. Key steps in scaling up these reforms could include:

- a. **Hospital Autonomy and Provider Payment:** The completed case payment method, and increases in management autonomy introduced in four tertiary hospitals could be extended to oblast hospitals. To make this work effectively, some revision the current details of the regulations and operation of the Treasury system would be needed, alongside strengthening of OHD and hospital financial management capacity. Over time, it should be possible to move from this simple system of a single price for each hospital, to a simplified case-mix system based on the CRH pilots, in a series of stages, beginning with use of case-mix and hospital costing information for benchmark comparisons, and gradually moving towards case-mix based payment based on standard case weights.
- b. **Standards and Performance Monitoring:** The secondary care standards being developed by MOH could form the basis for establishing a modern system of hospital performance monitoring, inspection and accreditation, and supported by training. It may be possible to supplement clinical care standards with complementary standards for efficiency, good management (covering financial management, human resource management, clinical management, information systems, etc), and patient satisfaction. A number of countries have developed balanced score-cards for monitoring hospital performance based on assessment of the level of standards compliance, and have used these to monitor hospital performance improvement over time and compare performance across hospitals, as part of strategies for creating incentives for continuous quality improvement. This could be considered in Uzbekistan.

31. **Complementary Options to Consider:** Options that might complement the Government's existing hospital reform initiatives could be considered, include:

- a. **“Market research” and business planning requirements for self-financing hospitals and diagnostic centers:** Although the Republican Specialized Centers providing tertiary services have been successful in generating increased revenue from self-financing patients, these facilities have the advantages of a large and relatively better off urban catchment population, and national prestige. It is not clear whether all oblast level facilities and diagnostic centers would be able to generate sufficient funds to be financially sustaining after they are upgraded and re-equipped, particularly in smaller and poorer areas, and given the relatively low current levels of utilization of many hospital services. It may be wise to introduce a requirement for “market research” of the local population's willingness and ability to pay for upgraded local services, and a requirement for development of a costed business plan for the oblast multi-profile hospitals and diagnostic centers before investment goes ahead.
- b. **Institutional responsibilities and capacity for regulation, monitoring and purchasing:** The new standards developed by the MOH, and the planned new regulations for private healthcare providers will need increased institutional capacity. There will be a need to define and clarify the role of the central MOH and OHDs in monitoring hospital performance against the standards, and to define

institutional responsibility for private hospital regulation. There can be strong benefits from having centralized capacity for analyzing hospital performance data, and benchmarking to support the OHDs to carry out their local responsibilities more effectively. There are advantages in giving a degree of institutional independence to the agencies responsible for monitoring hospital standards in the public and private sector. As completed-case payment is implemented at oblast and rayon level, the role of the OHD and the oblast and rayon finance departments in budget planning, in-year adjustments to hospital resource allocation to address variation in demand, and monitoring of hospital activity and expenditure will need to be developed.

- c. **Incentives for performance improvement:** Hospital autonomy and provider payment changes should increase incentives for efficiency. Alongside this, methods for increasing the incentives for hospitals and doctors to meet modern standards for clinical quality and patient satisfaction, and for ensuring equity and protection of the poor are needed. There is a range of ways to motivate hospitals to increase standards, that could be considered, ideally a combination of several methods:
- (i) OHDs, with MOH support, could negotiate performance agreements with hospitals, monitor progress;
 - (ii) MOH could develop a “balanced scorecard” for tracking and comparing hospital performance, and could use this to create reputational competition – e.g. by dissemination hospital assessments to health system managers and primary care providers, publishing scorecards in the MOH’s health sector publications and/or on the MOH website;
 - (iii) MOH and/or OHDs could link part of their funding for hospitals to achievement of progress in compliance with MOH standards, and any other performance targets; this could be supplemented with an awards program for hospital managers who achieve improved performance on these measures;
 - (iv) For hospitals with continuing low performance, a technical support team from the MOH and from well performing hospitals could be commissioned to provide advice to the hospital management team on how to address performance problems. Local hospital managers will also need increased human resource management powers to discipline poorly performing staff, and to address problems of excessive or inappropriate staffing.

D. Internal Management Issues

- *Clinical Issues*

32. *Although the Republican Specialized Centers have modernized their medical practice, and are well linked to international developments in their fields, this knowledge is not yet reaching most oblast and rayon/city hospitals, where (except for the Emergency Medical Care Network) care continues to be based on outdated clinical practices and long hospital stays.* Clinical services in many hospitals are not evidence based, do not necessarily address population health needs and continue to be organized around disconnected vertical delivery systems. There is no clear definition of services that should be provided at the secondary level. It is important to redefine the package of services to be provided by each of the secondary inpatient-care systems, namely central rayon hospitals, city hospitals and oblast hospitals. Case management founded on quality improvement techniques, evidence-based medicine and up-to-date clinical practice guidelines (protocols and standards) is largely absent. As well, there is a need to strengthen coordination with primary care, especially for clinical management of patients with chronic

conditions. Of critical importance in this regard is to assess the future educational needs of hospital providers (physicians, nurses and other medical staff) and suggest a sustainable organizational arrangement for training new staff and re-training existing staff in modern clinical practices. Training is another important mechanism for supporting compliance with the MOH's modernized secondary care standards. Lessons for how to upgrade clinical quality and support clinical staff could be drawn from the experience of the Emergency Medical Care network. This network is integrated into the CRHs, and has the potential to form the core for development of effective, efficient multi-profile hospitals at CRH level and oblast level, covering both emergency and planned admissions and outpatient/daypatient care.

33. ***Diagnostic and medical equipment is outdated, especially in the rayon, city and oblast-level secondary facilities.*** Except in the upgraded EMCs, equipment is typically 20 years or more old, and much of it is not functioning. Adequacy of equipment is often an obstacle to increasing use of day-surgery and outpatient treatment. ***Technical maintenance of the medical existent equipment is absent and facilities often lack needed reagents for diagnostic tests. Sustainability is compromised by proliferation of laboratory and diagnostic departments across the fragmented facilities network.*** A sustainable system of equipment-operation that includes provision for supplies and reagents, spares and refurbishment to ensure long-term and appropriate utilization of the capital assets needs to be developed. Experience with primary care reform in Uzbekistan highlights the need for a systematic approach. The model used for maintenance of primary care by a specialized corporation could be adopted. The MOH and MOF's proposal to establish a medical equipment leasing/servicing company could also be explored, and could be the subject of a PPP.

34. ***Lack of medicine supplies in sub-national public health facilities is a commonly sited complaint. To meet the gap, private pharmacies have now opened up around the entrance of many public hospitals.*** Procurement and distribution of most medicines is organized centrally, through a state-owned joint stock company, Dari Dalmond. Republican institutes and larger hospitals can also do their own procurement of medicines, and some find it efficient to do so for commonly used items, for which tendering can achieve lower prices. The major barrier to adequacy of drug supply in sub-national hospitals and clinics is reported to be the declining budget allocation for non-salary operating costs.

- Human Resource Management Issues

35. ***Current hospital staffing structures are based on norms issued by the Ministry of Health, and are not aligned with the services produced by respective hospitals.*** Hospital authorities have very little flexibility to hire and fire staff according to their real needs. The existing remuneration package and incentive schemes are inadequate to attract and retain good staff (except in the Emergency Medical Care network, and the Republican Specialized Centers). Staff are permitted to work in private clinics after hours, and many do. Hospitals may need flexibility to create non-traditional staffing arrangements such as payment by contract instead of salary, payment of doctors based on output/productivity, sharing of staff and ancillary services among hospitals, etc. To achieve efficiency and better performance, future hospital reform needs to examine mechanisms that could encourage optimal staffing – providing greater freedom and incentive to reduce staff numbers, such as through early retirement or re-deployment - and remuneration that is more aligned with market conditions, and related to performance. Republican specialized institutes with high levels of self-generated revenues are already able to do this. The Republican specialized surgery center, for example, has been able to double staff salaries on average using these revenues. For Central Rayon Hospitals in particular, which have only trivial levels of self-generated revenues, there is very little scope to use supplementary remuneration to motivate staff. Salary is not the only consideration. Lack of equipment, supplies, and the poor condition of facilities also demotivates staff, and leads to low hospital

utilization. With the exception of EMC staff, many Rayon hospitals and some oblast hospitals may have very few staff working in the afternoons and after hours.

- *Financial, Logistics and Asset Management Issues*

36. **Hospitals with new provider payment systems will need expertise in modern healthcare management in order to assess and improve efficiency.** Facility managers need to be able to plan and manage their own budgets, with greater flexibility in budget execution. Increasing health management knowledge and capacity will be a priority to enable health managers to function with more management autonomy. Increased transparency, accountability and control over management of self-financing revenues is needed, but should be handled in a way that maintains incentives to collect revenue and reward performance.

37. Estate/asset management, including safe clinical waste management, needs modernization. There have been serious concerns about infection management and the safety of blood transfusion at the hospitals. Concerns regarding this issue in particular given the emerging prevalence of HIV/AIDS has already been recognized and highlighted in Presidential Decree No. PP-700. There is little incentive currently to make efficient use of land and buildings, or to free up surplus assets for disposal. Changes to regulations to increase local retention of planned asset sales proceeds may help to mitigate local opposition to consolidation of multiple hospitals.

38. **Actions to Strengthen Internal Management:** Presidential Decree No. PP-700 includes a number of measures to strengthen clinical training and clinical management, general management, equipment maintenance, and blood safety. Complementary measures are needed to address financial management, asset management, human resource management and health information systems.

Conclusions and Summary of Recommendations for Follow-Up

39. This note refers to a wide range of problems and challenges. The Government's proposals for hospital development in Presidential Resolution PP-700, and its existing reform initiatives in the four tertiary hospitals provide foundations for addressing many of these issues, though complementary measures would be needed to address all of them. Extending reform to oblast and rayon hospitals raises some new issues, arising from the decentralized organization of the sector, lower management capacity in sub-national facilities and administrations, and the lower "purchasing power" of poor and near-poor patients in many regions and rural areas. The approach proposed in this Policy Note is to build incrementally on the Government's initiatives to achieve the goals of improved quality, efficiency and access to specialized healthcare at sub-national level. There are some useful general lessons from international experience with hospital reform, but there are also lessons to be drawn from the successes Uzbekistan has achieved in primary care reform as well as the obstacles and delays encountered in previous attempts to pursue planned hospital rationalization. These experiences point to the need for a comprehensive approach to reform. In relation to the universally difficult challenge of consolidating hospitals and downsizing staff, it may be more fruitful to approach reform via objectives and approaches that resonate better with clinicians and patients, subject to a budget constraint, and reinforced by incremental improvement in incentives. In other areas in which the Government has already initiated reform, progress could be rapid, rather than incremental – such as in development and implementation of new standards for clinical practice and management, clinical and management training, and provider payment reform.

40. There are two major areas where there is a need to **clarify future policy intentions** and resolve issues in the interface between different strands of the Government's policies, so that the foundations for future hospital reform are clear:

- a. There is uncertainty about whether the Government is seeking to reduce budget expenditure on hospital care alongside increased self-financing from user fee income and whether it plans to require most patients to pay the full costs for their hospital care in future. Although previous Presidential decrees on health reform signaled the intention to move to extensive reliance on self-financing, the Government clearly has been concerned about the potential impact on households of high cost health care, and has slowed and modified implementation of the policy, though in a somewhat *ad hoc* manner. There is uncertainty about the Government's medium to longer term intentions about how to protect patients from unaffordable health care costs, in particular the poor and those with chronic or high cost conditions. However, the existing voucher system could provide a starting point to build upon in developing a more systematic and comprehensive safety net.
- b. There are unresolved issues between the aspiration to extend the tertiary hospital model of hospital autonomy and completed-case payment to oblasts and rayons on the one hand, and the effects of new Treasury system regulations that increase the rigidity of input-based budget allocation for health facilities and reduce financial management capacity in OHDs and hospital on the other;

In the first of these areas, further research and analysis may help to identify the impacts of policy choice, and inform resolution. In the second of these areas, multi-sectoral dialogue is needed about the scope for revising and refining the operational regulations and responsibilities under the new Treasury system. There is a need to engage with the inter-relationship between Treasury and budget execution systems and health reform at a detailed level, to ensure that these reforms complement and reinforce each other.

41. **Over the next three to four years, it would be useful to conduct a program of studies and research to address knowledge gaps** that could help the Government to develop its longer term policy directions. The program could include the following elements:

- a. Investigation of the extent to which households are experiencing catastrophic health care costs arising from hospital treatment, and the reasons for this could help to provide a basis for revising existing financial protection methods. Some existing poverty survey data and disability studies could provide part of the data needed for this work. Based on this kind of information, it may be possible to simplify and streamline existing systems of financial protection and/or undertake information interventions to inform primary care doctors and patients.
- b. It would also be useful to commission research into the causes of the unusually low utilization of hospital and other specialized care by middle aged and older people.
- c. Human resource studies of clinical and non-clinical staff productivity, skill-mix, remuneration (in public sector and out-of-hours), and career path incentives, for staff in sub-national hospitals, particularly the Rayon hospitals.

42. The intention of future World Bank support for hospital reform would be to assist the Government in a comprehensive approach that covers:

- upgrading of facilities and equipment, focusing on priority needs in rayon hospitals that will undergo consolidation and development under PP-700;
- increasing clinical skills,
- motivating hospital staff through changes to pay and human resource management policies,
- strengthening hospital management,
- strengthening the MOH and Oblast institutional capacity for sector leadership, performance monitoring, purchasing hospital services, and regulation of the emerging private sector,

- hospital payment reforms, building on the completed case payment proposals and experience to date with completed case payment,
- other aspects of hospital financing – including future development of policies on vouchers or other protection for socially vulnerable groups, self-financing policies, and systems for protecting patients from high costs of hospital and specialist health care.

43. **In the shorter term (next 12-18 months) technical assistance** on details of policy design and implementation planning for a comprehensive hospital reform program could be beneficial, building on PP-700, and helping to design the proposed future World Bank support for hospital reform and development. This short term work program could usefully cover the following areas:

- a. Development of hospital service improvement programs for rayons and oblasts to develop more effective, higher quality services for non-communicable disease; this could draw upon the outcome-oriented approach used in the recently completed Navoi improvement plan; it may make sense to carry out this kind of analysis for a whole oblast, though the main focus of future World Bank investment lending support is expected to focus on rayon-level hospitals;
- b. Support for “market research”, feasibility studies and business planning for the proposed new self-financing diagnostic centers; the IFC may have an interest in supporting exploration of the feasibility of establishing and investing in public/private joint ventures to own and operate these centers and lease and service medical equipment for hospitals at Republican Level and in other larger cities;
- c. Assistance to the republican and oblast authorities to define and develop the institutional responsibilities and capacity for monitoring of public hospital standards/performance, the “purchasing” function for oblast and rayon hospital services, and the regulation of private hospitals.
- d. Development of detailed implementation regulations/guidelines for the case-based payment system for rayon hospitals, building on the pilot proposal developed for Ferghana; part of this work should address the need for any refinement of current operation of the Treasury system, and revisit the appropriate division of roles between the OHD and the OFD staff in managing within-year adjustments within the annual budget ceiling for their local hospitals;

44. **In the medium term (next 2-3 years) technical assistance** on further development and implementation planning for comprehensive hospital reform could be carried out, as part of or in conjunction with the proposed future World Bank support for hospital reform and development. This medium term work program could usefully cover the following areas:

- a. International expert advice on modern hospital functional planning and specialist hospital architectural design, to prepare for investment in upgrading rayon hospitals and multi-profile oblast hospitals;
- b. Evaluation of the case based hospital payment pilot in Ferghana, also drawing on review of lessons from the experience of the Republican Specialized Centers with completed case payment, followed up with development of a transition path for scaling up the pilot, and extending the completed case payment system to multi-profile oblast hospitals, alongside scaling up of HMIS;
- c. Development of a “balanced score-card” methodology for monitoring and comparing hospital performance over time, building on the MOH’s secondary care standards;
- d. Assistance to the republican authorities to define and develop the institutional responsibilities and capacity for the regulation of private hospitals, private diagnostic facilities and other private clinical practice.

45. In a number of areas, PP-700 already provides a clear indication of **areas for investment**. This includes development and institutionalization of training programs (clinical training for oblast and rayon/city hospital staff, hospital management training). Other potential areas for investment could be identified and specified as outcomes of the technical assistance identified in paragraph 43 a. (oblast improvement programs for NCDs) and 44 b. (feasibility studies for diagnostic centers). Finally, there is a need to identify options for provision of ongoing technical assistance to support the short and medium term programs for development of comprehensive hospital reform.