

Annex A: Kazakhstan Country Findings

Background: Health reform in Kazakhstan began in 1992 when the Ministry of Health (MoH) issued their paper titled “The Concept of Health Care Reform.” Implementation of this program was getting underway in 1994 just as the first Zdrav project was gearing up. Zdrav program managers embraced the Ministry’s concept and quickly established a role as technical advisers to support the reforms. By 2001, prospects were good for rapid progress in health reform because the economy was growing, successfully attracting foreign investment, and progressive reforms had been undertaken in the financial and social sectors. But soon thereafter, an attempt to establish national health insurance failed when the fund encumbered large deficits, stalling health financing reforms for several years.

By 2004-2005 the favorable economic conditions and newly appointed, enlightened leadership in the Ministry of Health reenergized reforms in important substantive ways. Through a participatory process between the government, ZdravPlus, WHO and the World Bank, the State Health Care Development Program (SHCDP) (2005-2010) (also known as the National Programme of Health Care Reform and Development), was developed and adopted along with a well formed legal and regulatory base. This program increased the stability of the health sector, and included the foundations of the system reform that ZdravReform had promoted in the 1990s and had judiciously nurtured for almost 10 years. The elements included establishment of a Budget Code for funding the Guaranteed Benefit Package through oblast pooling of funds, rules on the new payment methods, patient choice of primary care facility and the Health Care System Law authorizing the single-payer system – the foundations of the system reforms. National implementation of the plan was initiated in 2005 just as ZdravPlusII was launched. In interviews we were told that the government’s top priority is to strengthen primary care. ZdravPlus II’s three part country strategy is 1) to support their Kazakh partners in the implementation of this plan and 2) to support the GOK and the World Bank in the implementation of the Health Sector Institutional Reform and Technology Transfer Project (IRTT) co-funded by the GOK and WB, and 3) to solidify family medicine and improve service delivery in priority areas.

Comment [U1]: Should this read Health Care Code as we refer to it at the top of page 3?

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With a goal of accession to the WTO, the government has been a highly motivated partner to ZdravPlus II as they have collaborated to improve the performance of the health care system. The Vice Premier has committed to doubling the budget for the health sector, but he wants the new funds to go into a reformed system. The GOK views ZdravPlus II as their “right hand” in health sector reform and consider the staff to be more important advisers than the World Bank because of their exceptional analytical, mentoring and interpersonal abilities. They greatly fear losing their help at this important time.

In their opinion ZdravPlus II’s assistance to them has been critical to the advances made thus far in transforming the Kazakh health care system.

Performance Monitoring Plan Analysis: ZdravPlus II is making exceptional progress in meeting the targets set in the Performance Monitoring Plan (PMP). For 2007, the project is almost reaching, meeting, and in some cases exceeding significantly its 2009 end-of-project targets. Particularly noteworthy is the progress towards increasing the percent of total outpatient visits in primary health care practices in the pilot areas (achieving 61% in 2007 compared to its 2009 target of 59%) and nationally (57% in 2007 compared to its 2009 target of 45%); the number of entities to empower a community or individual (192 in 2007 compared to the 2009 target of 160); the percent of post abortion women accepting modern family planning methods (71% in 2007 compared to its 2009 target of 41%); and the number of products used for public outreach and advocacy (24 in 2007 compared to 10 in 2009). Given the impressive progress against most targets, the Mission, ZdravPlus II, and the GOK should accept due credit for this performance but consider resetting the 2009 targets to higher levels. Doing so could also provide an opportunity for these and perhaps other donor partners to suggest the “critical mass” of achievement signaling the phase-over of replication responsibility to the GOK. Critical mass might be defined by indicators such as successful implementation covering 60% or 80% of the population; 80% performance against the EU indicators in the graph above; reaching 80% of Millennium Development Goals.

Stewardship: The Stewardship component includes six sub-components in Kazakhstan; and, within these, a total of about 18 individual initiatives to create a comprehensive and coordinated framework for stewardship of the health sector. One of the priorities of ZdravPlus II during 2005-2007 was to support and promote full implementation of the State Health Care Development Program (SCHDP).

Since 2005, the Ministry of Health (MoH) has formed implementation working groups and has shown a high level of commitment to embedding the reforms in the day-to-day operations of the health care system. The challenges faced by Kazakhstan over this period have been to translate the policies into implementation strategies, to identify additional areas of policy change needed to fortify the reforms, to fend off attempts to undermine the strategy with alternative financing proposals and to lock the reforms into the legal system.

With the appointment of a new Minister and other MoH leaders in early 2007, ZdravPlus II devoted the past year to broad policy dialogue and training for MoH leaders to inform and educate them about the SHCHP and the critical health reform priorities. In addition, Zdrav sought to build capacity in the MoH staff to promote competency in the implementation of the reforms.

ZdravPlus II's semi-annual reports document a highly active program in the policy arena. They cite progress in 23 substantive areas, a testimony to the multi-faceted nature of system reform and to the depth and breadth of their technical knowledge. Besides serving as advisers to 9 working groups at the Ministry, they have been intimately involved as neutral advisers to the World Bank and the Government of Kazakhstan regarding the design of the recently approved World Bank Health Sector Institutional Reform and Technology Transfer Project (IRTT), which is co-financed with the Government of

Kazakhstan. They have also provided technical support in the development and implementation of the new incentive-based provider payment systems for primary health care physicians and hospitals, the new roles and responsibilities of the different levels and institutions of government, oblast medical information centers, the National Integrated Health Information System, the Outpatient Drug Benefit Package, and the new Council on Standardization and Assessment of Medical Technologies, which is charged with reevaluating old clinical protocols. In other words, they are involved in every area of reform from visionary policy matters to the practical considerations of implementation.

Five examples where ZdravPlusII's analytical insights and technical guidance have been particularly notable are

1) Health Care Code - ZdravPlusII filled an instrumental advisory role to the Ministry in the development of the Health Care Code. The Health Care Code carries the highest level of legal force, and assures sustainability of the reform agenda in a way that the SHCDP (adopted as a President Decree) does not. Through their close involvement in the drafting process, ZdravPlusII secured improvements in the new provider payment systems, allocation of responsibilities between the levels of government and the conditions for private sector development.

2) National Budget Formation and Treasury System – These two national governance systems are presenting major obstacles to health reform. Kazakhstan's current budgeting and payment systems are rigid and based on the old Soviet style budget chapters for funding inputs. Through the pilot in Karaganda Oblast, ZdravPlus II learned that the full benefit of the new provider payment systems will not be achieved as long as the restrictive bureaucratic accounting systems are in place. For instance, Oblast Health Departments cannot now reallocate funds from hospitals to primary care, a critical prerequisite to system restructuring. Zdrav has reached across the government to the Ministry of Economy and Budget Planning and to the Vice Premier to explain how the reforms are constrained by these systems. They have successfully argued for revisions that are now being developed; and in the course of this effort, gained well-positioned allies to help advance the health reform agenda.

3) Public Finance Reform – a ZdravPlusII presentation on the aforementioned inefficiencies of the Treasury system prompted the Vice Premier and the Ministry of Economy and Budget Planning to meet further with the project on the issue. As a result, three other ministries are piloting new approaches similar to the one ZdravPlus II advocated for managing health funds. The project has thus influenced the government to look beyond the health sector to address public finance issues more broadly.

4) Maintaining pooling of funds at the oblast level and single-payer structure – These two elements of the reformed system are the centerpiece of moving money in new ways to increase efficiency, quality, responsiveness and equity of the health care system. In the past year, there have been efforts to undermine these structures through further decentralization of the pooling function to the rayon level (Kazakhstan is already the most decentralized country in the CAR), introduction of national health insurance and

other alternative financing mechanisms. As a result of ZdravPlus II's vigilance regarding developments in the Parliament and their access to influential leaders, they were able to sound the alarm that these pillars of the reform (that had been in place since 2005) were threatened. Had the sponsors of the alternative financing methods prevailed, years of investment on the part of USAID would have been lost, however, the direction of reforms is still on track. This incident highlights the importance of assuring that reforms have a strong legal authority and that successful models are publicized and rolled out as quickly as possible.

5) Intervening into crisis situations – A few years ago the MoH was planning to buy ineffective drugs for TB treatment. ZdravPlus II stepped in and appealed this decision and successfully had it reversed.

In a lengthy interview with the Vice Minister of Health, appointed about one year ago, and the Head of the Strategic Development and International Cooperation Department, they said that few people in the Ministry have mastered an understanding of the complex social and economic nature of the health care system. They cited multiple examples of the training and analytical assistance ZdravPlus II had provided to help them better grasp the challenges and opportunities inherent in reform of the health sector. These included analysis of the national Treasury System and its impact on financing reforms in the health sector, administrative reforms within the Ministry, strategic budgeting, efficiency of the hospital sector, development and improvement of indicators of performance, structural adjustments of the sector, among others. The results of ZdravPlus II's analysis have led to adoption of family medicine and evidence-based medicine as national priorities and have strongly influenced the final design of the World Bank's Health Sector Institutional Reform and Technology Transfer Project (IRTT).

Currently, the Ministry's objectives include the following: roll-out of reforms to more oblasts, which will require several more years; breaking down the walls between hospitals and primary care to further stimulate development of primary care; outcome-based budgeting, which is scheduled to be implemented over the 2008-2013 period; harmonization of the laws and regulations governing the health care system, including the Health Care Code; and work on National Health Accounts, part of the health information system that ZdravPlus II is helping to design and implement.

In a meeting with the World Bank, the MoH assessment of ZdravPlusII's contribution to the health system reforms in Kazakhstan was reinforced. The Senior Health Specialist for Europe and Central Asia Region, indicated that ZdravPlus II staff, Sheila O'Dougherty in particular, had brought substantial intellectual capital to health reform across the region. Most recently, in his work with her and the ZdravPlus II staff on the design of the new World Bank project, he found their contextual knowledge of the complex health sector operations an invaluable resource. He expressed alarm at the prospect of the Zdrav capacity not being available to the implementers of the World Bank project.

Impressive results have been achieved in the Stewardship area under the project to date. A comparison of the priority elements that ZdravPlus II identified in the 2007 work plan

with the six month reports of 2007, indicates that some of the elements mentioned in the work plan (i.e., the pharmaceutical activities in the service delivery component and the incorporation of evidence-based clinical content in the Basic Benefit Package (BBP)) are not addressed under the same component or title in the semi-annual report. A cross walk between these two documents is, therefore, not precise. A sample of references indicates that the work plan was fully implemented under one component or another.

Resource Use: Between 1999 and 2005, public expenditures on health care grew almost five fold and the capitation rate had been increased from its 1998 original level of 19.5 tengue per person per month (pp/pm) to 160 tengue pp/pm. With this increase, primary care physicians are now providing more service and more preventive care. Within the design of health system reform in the CAR, the pooling of funds at the oblast level and the oblast single payer system are a centerpiece. Documents prepared by *ZdravReform* in 1999 state that “the single most important issue for institutionalizing new provider payment systems and allowing them to drive the rationalization of the health sector is addressing the constraints to pooling of health care funds at the oblast level and allocating health care resources without budget chapters.” [Lessons Learned and Next Steps in Health Reform for Central Asian Republics, *ZdravReform* paper, October 1999.]

Since that time, the economic conditions within Kazakhstan have changed, and along with them the most compelling rationale for these three components of reform has changed. It has shifted from changing the providers’ behavior through new incentive-based provider payments to an emphasis on the single payer system and pooling of funds at the oblast level in order to “provide equity and relatively equal financial risk protection for the poor and vulnerable populations, critically important as both income and the income gap is growing.” (Work plan 2007)

The difficulty of achieving acceptance for transformational ideas is obvious from the concentrated effort that *Zdrav* has had to invest in this topic over the past 7 years; though as noted, from 2001-2004, the government did not support health reform at all. For the past three years, *ZdravPlusII* has defended and protected the single payer and oblast level pooling against those with vested interests in other approaches. By working closely with the World Bank and the MoH in the design of the new World Bank project, *ZdravPlusII* has nurtured support for these institutional mechanisms, established some political buffers and has greatly improved the prospects that the financing system will be durable.

The World Bank project also includes components to address two of the weaknesses in the current operation of the single payer system. Up to this point there has been inadequate human and technical capacity to perform the various management functions associated with this structure. Staff has not been well trained for positions in financial and general management or information systems management. Autonomous facilities also demand management expertise to survive. In addition, the information systems are not developed sufficiently to assure transparent and accurate flow of funds. Investments in human capacity and information systems development are included in the World Bank loan.

Essential to implementing the new provider payment systems is the development and implementation of a health information system. ZdravPlusII has helped establish Medical Information Centers as independent legal entities, determine their functions, and train their staffs. The evaluation team visited the offices for the original pilot HIS system located in Karaganda. Karaganda Oblast has the most developed Medical Information Center with three functions: 1) collecting monthly data from providers which is used for both clinical and financial purposes, 2) preparing analytical reports and funding requests for the Treasury, and 3) developing indicators for monitoring and analysis of the health care system. The GOK is now directing that the system be implemented nationwide. It will produce the data for the PHC two-step performance-for-pay system the GOK plans to implement soon.

The Director of the Medical Information Center in Karaganda, who has been engaged in the development of the Center and the health information systems since its inception, said she highly values the technical assistance and training provided by ZdravPlusII and predecessor projects, expressing her desire that they continue receiving assistance well beyond the next two years. The HIS system is to be implemented nationwide in 2010, but only two oblasts (EKO and Karaganda) currently have functional systems. Other oblasts are doing data collection, but forms are not uniform, creating significant technical challenges for the nationwide system. She attributed the successful development of the HIS in Karaganda Oblast to the long-term relationship she has had with the project, noting that while high-level MoH officials have changed often, those at the mid-level, such as herself, have enabled the government to successfully implement the HIS and other reform initiatives. ZdravPlusII assisted the World Bank in developing scopes of work for consultancies related to the HIS component of the World Bank IRTT Project.

Health system restructuring centered on primary care is another centerpiece of the health system reform strategy. As with all the reforms promoted by ZdravPlusII, the State Health Care and Development Program (SHCDP) Implementation Plan is the vehicle for formalizing adoption within the government. To provide incentives to oblast governors to support the strengthening of primary health care, ZdravPlus II successfully suggested to the MoH that their performance ratings include assessments of their commitment to institutionalizing primary care. The indicator adopted is “percent of expenditures to PHC of the oblast health budget.” [July-December 2007 WP] ZdravPlus II’s attention to this seemingly minor incentive “in the weeds” may turn out to be one of the most powerful tools for restructuring the health system.

ZdravPlusII concluded that the availability of affordable medicines is crucial to strengthening PHC and has assisted the GOK in establishing and expanding an outpatient drug benefit program (ODBP). A ZdravPlus II funded evaluation of the program’s performance in 2006 by the Drug Information Center (DIC) found that 1) procurement prices varied across regions; 2) drug needs were poorly estimated due to inadequacies in the information management system; 3) too few pharmacies were participating; and 4) most of the ODB drugs have A or B+ clinical effectiveness. After ZdravPlusII briefed the MoH on the findings and the Kyrgyzstan ODB experiences, the GOK decided to include ODB improvement in the WB project design. The project is developing a

methodology to establish national ODB drug procurement prices and modifying the program to improve access and affordability. Under its new loan, the WB is counting on ZdravPlus II to help with the design and implementation of an information system to manage the program, which will address one of the major weaknesses of the existing system.

The Drug Information Center (DIC) provides health providers and patients unbiased up-to-date information on clinical effects of medicine, side effects and possible interactions. In 2007, the DIC submitted a successful bid for an MoH grant to develop a National Drug Formulary Reference book, which lists all of the medicines that are on the National Essential Medicines List and provides a brief description of indications, dosage, common adverse affects, and counter indications for each medicine. The DIC has continued to issue quarterly drug bulletins and provide training seminars on rational drug use.

In the interview with the former head of Karaganda Oblast Health Department, she said the areas of greatest need for them to complete the implementation of reform are organizational management issues, implementation of partial fund-holding, efficient fund use, a critical mass of well-trained people who can be employed at health care facilities, rayon health departments and oblast health departments. The School of Public Health is in the process of developing a curriculum for management, information systems and health care financing and economies, but they need help. She noted other concerns as well, including implementation of hospital-based continuous quality improvement (CQI), still a new and unknown concept to Kazakh health professionals; design issues related to building and renovating hospitals as these impact on the quality of care; improving the infrastructure for primary care such as medical equipment, training in the use of financial information to make management decisions.

Service Delivery: To improve service delivery, ZdravPlus II has focused on improving the knowledge of physicians and use of CPGs by providing assistance through the KAFP, on strengthening medical school faculties, initiating a medical residency program in family medicine, and introducing family medicine departments into Medical Academies. Despite strong government backing, gaining legitimacy and full acceptance of family practice within the established medical institutions has been difficult. Academic leaders from the “old school” have been unwilling to totally embrace family medicine and EBM with the result that they are not yet institutionalized. Medical students have reflected this lukewarm reception. This year a family medicine residency program was initiated (which is a great step forward) and there were only 12 applicants for the first class. Six were selected and will finish their residency at the end of 2009. The quality of PHC and the benefits of PHC for the patients hinges on providers improving their clinical skills. The educational establishment must be a partner for this to happen; and thus far, it has been very slow to respond.

At the present time, the state of the art in education for physicians related to clinical practice guidelines is modular training. The National Center for Health Care Development monitors the implementation of CPGs. After initial assistance to help the

Institute expand, ZdravPlus II now has a role as adviser, providing technical papers when needed.

The Integrated Improvement Projects were established to combine training, CME, CPG implementation and quality monitoring at the facility level. The team visited IIP sites in Astana (Safe Motherhood) and Karaganda (Arterial Hypertension (AH) and Safe Motherhood), discussed the changes in practice with medical staff and patients, and reviewed the quality monitoring tools used to measure progress in implementation of best practices. At all of these sites, the program has been enthusiastically adopted and was working well with growing numbers of enrollees. The former head of the Oblast Health Department in Karaganda credited the pilot sites with causing a “revolution in thinking by the doctors.”

Cardiovascular disease is by far the leading cause of death in Kazakhstan (536/100,000 vs. 28/100,000 for infectious disease and 66/100,000 for cancer). ZdravPlusII’s goal is to increase the prevention, screening, diagnosis, treatment and monitoring of those with the disease or at risk for the disease. ZdravPlusII has been working to improve management of this disease since 2005 when clinical training of physicians first began. They served as advisers to the Cardiology Institute (CI), the leading research institute in Kazakhstan, and the Postgraduate Institute for Physicians (PGI) which developed the family medicine clinical practice guidelines (CPG) for arterial hypertension and conducted courses to train the trainers. Other partners include the Karaganda Oblast Health Department, KAFP, and the Drug Information Center. There is now a group of stakeholders who are trained in the EBM and CPG methodology and understand their role in development of future initiatives informed by EBM and CPG.

Outreach to patients with AH begins with counseling by their primary care physician regarding their condition and a referral to the educational programs conducted at the facility. The follow-up studies indicate that patients are responding favorably to the program.

KAFP is responsible for facilitating the implementation of the AH CPG. Six pilot sites in Karaganda oblast were selected for the initial implementation of the new AH program and it has now expanded to three additional oblasts.

ZdravPlus II taught KAFP how to do medical record audits and with these skills they are able to monitor quality at AH pilot sites in Karaganda Oblast, selecting one indicator at a time to monitor. Results show that in pilot sites case finding has significantly improved, physicians are prescribing appropriate meds more often, patient practices have improved, complication rates are lower and blood pressures are better controlled. The first indicator was blood pressure screening (2006-2007) and the second to be implemented thus far is measuring and recording patients’ body mass index (BMI). At the site we visited, the staff was enthusiastic about what they had learned about evidence-based medicine and proud of the opportunity to offer modern medical practices to their patients. They admitted that learning a new way to treat their patients was not easy, but they are now pleased with their heightened awareness of this medical condition. They expressed

concern about the lack of blood pressure cuffs and stethoscopes for visiting nurses. The reductions in death rates from cardiovascular disease at the pilot sites in Karaganda are expected to become apparent within the next three years. In 2008, KAPF will work through the family group practices to roll out the AH program CPG Clinical Training Module to two other oblasts and the city of Semipalatinsk.

Safe Motherhood is a WHO program designed for the former Soviet bloc countries and tested in Ukraine. Implementation began in the CAR in 2005. WHO and ZdravPlus II are collaborating on training. The team found that the Family Planning/Reproductive Health/Safe Motherhood IIP sites were well supplied to conduct their programs. They are reporting high satisfaction of providers and patients, which we confirmed in our interviews with both patients (one with a partner) and medical staff. A quality monitoring program is built into the SM pilots. It tracks 26 indicators of effectiveness which are linked to the three SM service training modules. Data on these indicators is compiled at least annually from patient surveys and chart reviews. Baseline data was collected at all 11 pilots; and the reports showed that overall care has improved. There were some areas at each site where performance was not sustained and where appropriate change was not occurring. The most important aspect of these reports is that problems areas are easy to identify for follow-up, though use of the feedback loop appears to be uneven.

Hospital leaders have already seen that the Safe Motherhood program can rather quickly demonstrate reductions in infant and maternal deaths. For instance, in Karaganda Oblast SM hospitals, the average length of stay (ALOS) and cost per delivery have decreased. The number of deliveries has increased from 18,000 in 2002 to 22-24,000 in 2007, while infant deaths have declined from 22/1000 to 12/1000 over the same period. Continuation and sustainability of these programs is highly probable because a well-structured training of trainers program has been established and trainers are willing to serve without pay. The cost of physician and patient training materials is absorbed by the facility budget.

Safe Motherhood is not yet part of the medical school curriculum in Kazakhstan, but a multi-disciplinary working group is developing of a prekaz for safe motherhood.

The Red Apple Hotline, implemented through the Kazakhstan Businesswomens Association and partially funded by ZdravPlusII, uses student peer trainers to provide family planning and reproductive health counseling services. During 2007, the Hotline responded to almost 45,000 calls. The Association began offering the hotline in Almaty and Karaganda and it is now available in 20 branches throughout the country. ZdravPlus II technical and materials assistance is valued highly. The Association welcomes continued support but is already identifying other funding sources to continue the hotlines after USAID assistance ends in 2009. These sources include local governments but other donors as well. The local branches have registered as NGOs and can receive local government funding. However, they still face funding issues. For example, in the Western region, the local government does not allow the MOH to allocate funding to NGOs. Similarly, the main association in Almaty can receive a national grant, but it can not distribute these funds among the branches. The Association seems well aware of the

need to strengthen the financial sustainability of the hotline program and is addressing constraints to doing so accordingly.

ZdravPlus II has been very successful in collaborating with Project Hope to integrate TB services into the PHC system. The PHC system is especially helpful in identifying new cases and providing DOTS services. The two projects and other counterparts participate in the national thematic working groups on TB. ZdravPlus II recently examined TB control in the prison system. Kazakhstan is a regional leader in penal reform, requiring the penal and civilian sectors to coordinate and assure that all infected people are followed and have access to meds. The project is also assisting with the development of the Kazakhstan National Guidelines on TB and MDR-TB Control in collaboration with the National TB Program and other international donor programs. The guidelines will contain detailed practical information for PHC and TB service providers. The collaboration between ZdravPlus II and Project Hope has the potential for developing new creative service delivery models that may have appeal within and beyond the CAR region.

Population and Community Health: According to the ZdravPlusII semi-annual reports, activities in this component focused on 1) promoting and marketing health care reforms to the MoH, oblast health reform implementers and health professionals and 2) educating the population on select health topics related to AH, FP/RH/SM, and the Exxon Mobile-USAID Global Development Alliance (GDA). The key implementers of these activities, besides ZdravPlusII, are three of its grantees, the Business Women's Association of Kazakhstan (BWAK), the Kazakhstan Association of Family Practitioners (KAFF) and the Drug Information Center (DIC).

ZdravPlusII has continuous interaction with officials in the government regarding the health reforms and the strategic vision they are working to achieve. This helps the GOK to maintain the focus when complexities and obstacles arise, such as with the Treasury System issues.

The Kazakhstan Association of Family Practice (KAFF) received its first grant from ZdravPlus in 2003. Its purpose is to promote the new profession of family medicine. They have become a successful training organization for EBM across the CAR. Their approach is to use clinicians as trainers and clinic sites as the classrooms. In this way, the training is practical, hands on with patients, and interactive between the physician trainers and the students. This is a completely new approach to medical training.

To implement the AH initiative KAFF supports the patient schools for AH, and promotes evidence based approaches to the treatment of asthma, and chronic obstructive pulmonary diseases. They produce posters that are displayed in public places, and use the radio to publicize information for the general public. ZdravPlusII is providing brochures and audio/video materials on AH to the National Healthy Lifestyle Center for copying and dissemination. Patient Clubs have been organized for a variety of conditions and these support groups are becoming more common.

ZdravPlusII has sponsored well-attended open houses at family group practices to attract public attention to these facilities and demonstrate the range of services available to patients.

Conclusion

ZdravPlus II has worked effectively with the Kazak government, helping them to develop a strategy for reforming the health care system and to gradually and sequentially begin implementation of that strategy. Its analysis and guidance has informed virtually all of the sweeping legal and policy changes governing the health sector in Kazakhstan. Its knowledge of systems operations has been skillfully applied to the design of pilot tests and troubleshooting of problems. Understanding the still tenuous nature of reform and the challenges that remain, government leaders are counting on ZdravPlus II to continue to have a central role. Under the new World Bank loan, both the Kazakh government and the World Bank see ZdravPlus II's role as critical to their success.

USAID is closely identified with the leadership position and deep respect that ZdravPlus II has gained with the GOK and the donor community. Though Kazakhstan's new wealth places it outside of the eligible range for funding beyond the current contract period, it is in the US national interest to continue its involvement with the Kazakh health reforms for two reasons. First, when the health care system is fully functioning, Kazakhstan will be an example of a "model" health care system, built from the ground floor to correct problems that were wasting scarce resources and poorly serving the health needs of the population. It has the potential to offer many global "best practices" in areas where international health experts are desperate for answers, such as how best to combine system strengthening with vertical disease/condition specific programs. The US's commitment to Kazakh reforms over an extended period merits well-deserved recognition for this breakthrough. Second, the project has generated enormous good will in an important part of the world. If the GOK is willing to provide a significant part of the operating budget while USAID maintains technical and management control, there will be a high return on the US investment as well as continued presence at a critical time in history.