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R2016-0064/1

April 8, 2016

Closing Date: Wednesday, April 27, 2016 at 6 p.m.

FROM: Vice President and Corporate Secretary

Kazakhstan - Social Health Insurance Project: Improving Access, Quality, Efficiency, and Financial Protection

Project Appraisal Document

Attached is the Project Appraisal Document regarding a proposed loan to Kazakhstan for the Social Health Insurance Project: Improving Access, Quality, Efficiency, and Financial Protection (R2016-0064), which is being processed on an absence-of-objection basis.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

Document of
The World Bank

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Report No: PAD1409

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$80 MILLION

TO THE

REPUBLIC OF KAZAKHSTAN

FOR A

SOCIAL HEALTH INSURANCE PROJECT: IMPROVING ACCESS, QUALITY, EFFICIENCY, AND FINANCIAL PROTECTION

April 6, 2016

Health, Nutrition and Population Global Practice
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 2016)

Currency Unit = Kazakhstani Tenge (KZT)
KZT 345.09 = US$1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BP	Benefits Package
CCMPA	Committee for the Control of Medical and Pharmaceutical Activities
CCT	Core Coordination Team
CG/CP	Clinical Guidelines/Clinical Protocols
CEO	Chief Executive Officer
CPFs	Country Partnership Frameworks
CPGs	Clinical Practice Guidelines
CPHS	Committee for Payment of Health Services
CPS	Country Partnership Strategy
DA	Designated Account
DALYs	Disability-Adjusted Life Years
DF	Department of Finance
DHSO	Department of Health Services Organization
DHSS	Department of Health Services Standardization
DIPDPPP	Department of Investment Projects and Development of Public Private Partnership
DMPs	Disease Management Programs
DRG	Diagnosis-Related Group
DSHR	Department of Science and Human Resources Development
EBP	Evidence-Based medicine
EMPs	Environmental Management Plans
EMS	Emergency Medical Services
EU	European Union
FED	Finance and Economic Department
FEMP	Framework Environmental Management Plan
FM	Financial Management
FMM	Financial Management Manual
GDP	Gross Domestic Product
GP	General Practitioners – Primary Care Doctors

GoK	Government of Kazakhstan
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
GVFHC	Guaranteed Volume of Free Health Care
HFA-DB	European Health for All Database
HR	Human Resources
HRH	Human Resources for Health
HTA	Health Technology Assessment
IBRD	International Bank for Reconstruction and Development
IC	Individual Consultants
ICB	International Competitive Bidding
ICPC	International Classification of Primary Care
IDA	International Development Association
IFRs	Interim Unaudited Financial Reports
IPF	Investment Project Financing
IPSGs	International Patient Safety Goals
IRR	Internal Rate of Return
JCQHS	Joint Commission on Quality of Health Services
KHSTTIRP	Kazakhstan Health Sector Technology Transfer and Institutional Reform Project
M&E	Monitoring and Evaluation
MHI	Mandatory Health Insurance
MHIF	Mandatory Health Insurance Fund
MoF	Ministry of Finance
MoHSD	Ministry of Health and Social Development
MSF	Multi-Stakeholder Forum
NCB	National Competitive Bidding
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHA	National Health Accounts
NPC	National Project Coordinator
NPV	Net Present Value
OECD	Organization for Economic Co-operation and Development
OOP	Out-Of-Pocket
PDO	Project Development Objective
PforR	Program for Results
PHC	Primary Health Care
PIST	Project Implementation Support Team
PIT	Personal Income Tax
PMU	Project Management Unit
POM	Project Operational Manual
PPP	Public-Private Partnership
P-RAMS	Procurement Risk Assessment and Management System
QBS	Quality-Based Selections
QCBS	Quality and Cost-Based Selection

RCHD	Republican Center for Health Development
SHI	Social Health Insurance
SHIF	Social Health Insurance Fund
STC	Short-Term Consultant

Regional Vice President:	Cyril E. Muller
Acting Country Director:	Mariam J. Sherman
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Enis Barış
Task Team Leaders:	Carlos Marcelo Bortman, Baktybek Zhumadil

REPUBLIC OF KAZAKHSTAN
SOCIAL HEALTH INSURANCE PROJECT:
IMPROVING ACCESS, QUALITY, EFFICIENCY, AND FINANCIAL PROTECTION

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PAD DATA SHEET

Kazakhstan

Social Health Insurance Project: Improving Access, Quality, Efficiency and Financial Protection

PROJECT APPRAISAL DOCUMENT

EUROPE AND CENTRAL ASIA

GLOBAL PRACTICE FOR HEALTH, NUTRITION AND POPULATION

Report No.: PAD1409

Basic Information		
Project ID P152625	EA Category C -Not Required	Team Leader(s) Carlos Marcelo Bortman, Baktybek Zhumadil
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]	
Project Implementation Start Date 27-Apr-2016	Project Implementation End Date 30-Jun-2021	
Expected Effectiveness Date 26-Dec-2016	Expected Closing Date 30-Jun-2021	
Joint IFC No		

Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Enis Baris	Timothy Grant Evans	Mariam J. Sherman	Cyril E Muller

Borrower: Republic of Kazakhstan			
Responsible Agency: Ministry of Health and Social Development			
Contact:	Bolat Tokezhanov	Title:	National Project Coordinator
Telephone No.:	77172742816	Email:	tokezhanov@mail.ru

Project Financing Data(in USD Million)					
[X] Loan	[ ] IDA Grant	[ ] Guarantee			
[ ] Credit	[ ] Grant	[ ] Other			
Total Project Cost:	90.00		Total Bank Financing:	80.00	
Financing Gap:	0.00				

Financing Source	Amount
Borrower	10.00
International Bank for Reconstruction and Development	80.00
Total	90.00

Expected Disbursements (in USD Million)

Fiscal Year	2017	2018	2019	2020	2021	0000	0000	0000	0000	0000
Annual	12.73	21.34	22.72	16.81	6.40	0.00	0.00	0.00	0.00	0.00
Cumulative	12.73	34.07	56.79	73.60	80.00	0.00	0.00	0.00	0.00	0.00

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	100
Total		100

Proposed Development Objective(s)
The proposed Project Development Objective is to improve accessibility, quality, and efficiency of health service delivery, and reduce financial risks to the population that are caused by serious health problems.

Components	
Component Name	**Cost (USD Millions)**
Component 1. Supporting implementation of the national mandatory Social Health Insurance system	16.63
Component 2. Strengthening of health service delivery to support implementation of the national mandatory Social Health Insurance system	62.94
Component 3. Project management, monitoring and evaluation, and communications strategy	10.43

Systematic Operations Risk- Rating Tool (SORT)	
Risk Category	**Rating**
1. Political and Governance	Moderate
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Substantial
9. Other	Substantial
OVERALL	Substantial

Compliance		
Policy		
Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01		**X**

Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10		**X**
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Project Operational Manual (POM)	**X**		CONTINUOUS

Description of Covenant

The Borrower shall: (a) ensure that the criteria set out in the POM are applied in connection with the carrying out of the Project; and (b) not amend or waive, or permit to be amended or waived, the POM without the prior written consent of the Bank

Name	**Recurrent**	**Due Date**	**Frequency**
Maintenance of the Project Management Unit (PMU)	**X**		CONTINUOUS

Description of Covenant

The Borrower, through MoHSD, shall operate and maintain the PMU, throughout Project implementation, under terms of reference and with functions, all acceptable to the Bank

Name	**Recurrent**	**Due Date**	**Frequency**
Staffing of the PMU	**X**		CONTINUOUS

Description of Covenant

The Borrower shall, under the purview of the MoHSD, ensure that the PMU is, throughout Project implementation, adequately staffed by personnel with qualifications, and under terms of reference, all satisfactory to the Bank

Name	**Recurrent**	**Due Date**	**Frequency**
Establishment of the Core Coordination Team (CCT)		25-Jan-2017	

Description of Covenant

Not later than 30 days after the Effective Date, the Borrower shall, through an order of the MoHSD, establish the CCT for the Project

Name	**Recurrent**	**Due Date**	**Frequency**
Composition of the CCT	**X**		CONTINUOUS

Description of Covenant

The Borrower shall maintain, throughout Project implementation, the CCT with a composition, resources, and terms of reference, all satisfactory to the Bank

Name	Recurrent	Due Date	Frequency
Composition of the Joint Commission on Quality of Health Services (JCQHS)	X		CONTINUOUS

Description of Covenant

The Borrower, through MoHSD, shall maintain throughout Project implementation, the JCQHS for the Project, with a composition, resources and terms of reference, all satisfactory to the Bank

Name	Recurrent	Due Date	Frequency
Composition of the National Health Care Coordination Council (NHCCC)	X		CONTINUOUS

Description of Covenant

The Borrower shall: (a) maintain, throughout Project implementation, the NHCCC with resources and terms of reference, all satisfactory to the Bank; and (b) ensure that the said council comprises the representatives of all concerned Borrower agencies and regional authorities

Name	Recurrent	Due Date	Frequency
Composition of the Social Health Insurance Fund (SHIF)	X		CONTINUOUS

Description of Covenant

The Borrower shall operate and maintain throughout Project implementation, SHIF with a composition, resources and terms of reference, all satisfactory to the Bank, to carry out the Project

Name	Recurrent	Due Date	Frequency
Subsidiary Agreement with SHIF	X		CONTINUOUS

Description of Covenant

In the event that the Borrower is no longer the sole shareholder of SHIF, (a) the Borrower, represented by MoHSD, shall enter into a subsidiary agreement with SHIF, under terms and conditions approved by the Bank; and (b) the Borrower, represented by MoHSD, shall exercise its rights and carry out its obligations under the said subsidiary agreement in such manner as to protect the interests of the Borrower, as represented by MoHSD, and the Bank and to accomplish the purposes of the Loan

Name	Recurrent	Due Date	Frequency
Automatic accounting software for IFRs		09-Feb-2017	

Description of Covenant

Not later than 45 days after the Effective Date, the Borrower, through the MoHSD, shall develop and launch, within its existing automated accounting software, a module to generate interim unaudited financial reports and to capture the Project's accounts, all to the satisfaction of the Bank

Conditions

Source Of Fund	Name	Type
IBRD	Disbursement under Category (1) for Part I of the Project	Disbursement

Description of Condition

For payments under Category (1) for Part 1 of the Project, unless and until the Borrower has furnished evidence satisfactory to the Bank that the Borrower has formally established SHIF as provided in Section I.A.6 of Schedule 2 to the Loan Agreement

Source Of Fund	Name	Type
IBRD	Establishment of the PMU	Effectiveness

Description of Condition

The Borrower has formally, through an order of the MoHSD, established the Project Management Unit (PMU), referred to in Section I.A.2 of Schedule 2 to the Loan Agreement

Source Of Fund	Name	Type
IBRD	Adoption of the Project Operational Manual (POM)	Effectiveness

Description of Condition

The Borrower, through the MoHSD, has adopted, to the satisfaction of the Bank, the POM, which shall include the community monitoring instrument and the grievance redress mechanism referred to in Part 3.C of the Project, and the financial management procedures for the Project

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Carlos Marcelo Bortman	Team Leader (ADM Responsible)	Sr Public Health Spec.	Health	GHN04
Baktybek Zhumadil	Team Leader	Operations Officer	Operations	GHN03
Nurbek Kurmanaliev	Procurement Specialist (ADM Responsible)	Procurement Specialist	Procurement	GGO03
Aliya Kim	Financial Management Specialist	Financial Management Specialist	Financial Management	GGO21
Aparnaa Somanathan	Team Member	Senior Economist	Health Insurance - Health Financing	GHN03
Ekaterina Romanova	Safeguards Specialist	Social Development Specialist	Social Development	GSU03
Gabriel C. Francis	Team Member	Program Assistant	Administrative and Operation Support	GHN03
Ha Thi Hong Nguyen	Team Member	Senior Economist	Health Economics	GHN03
Janelle Plummer	Team Member	Senior Social Development Specialist	Citizen Engagement	GSU03
Jasna Mestnik	Team Member	Finance Officer	Loan Operations	WFALA
Lisa Lui	Counsel	Lead Counsel	Legal Affairs	LEGLE

Rustam Arstanov	Safeguards Specialist	Environmental Specialist	Environment	GEN03
Shynar Jetpissova	Team Member	Communications Associate	Communications	ECAEC
Zhadyra Baibosynova	Team Member	Program Assistant	Administrative and Client Support	ECCKZ

Extended Team

Name	Title	Office Phone	Location

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required?	Consulting services will be needed

I. STRATEGIC CONTEXT

A. Country Context

1. **Kazakhstan is an upper-middle-income resource-rich economy, which is currently experiencing the negative impacts of a sustained decline in oil prices.** Kazakhstan's growth slowed from 4.1 percent in 2014 to 1.2 percent in 2015 as oil prices continued falling, affecting consumer and investor sentiment. Oil prices halved since mid-2014 and led to a twin deficit in the fiscal and external balances, putting pressure on the exchange rate. Unfavorable external conditions and poor economic performance forced the authorities to initiate an appropriate policy response, including a countercyclical fiscal policy to support domestic demand and employment and a move to a floating exchange rate regime since August 2015 to align domestic prices. The authorities have also been focusing on deepening institutional reforms to foster economic diversification and private sector development and increasing the size of the middle class.

2. **The long-term Kazakhstan 2050 Strategy, unveiled by the President of Kazakhstan in his Annual Address to the Nation in 2012, and the structural reforms envisioned in it foresee the country's transition to a knowledge economy within 10 to 15 years, and joining the top 30 most-developed countries by 2050.** Having implemented a number of successful strategic reforms during the last five years, the country has been focusing on diversifying away from resource-based growth through a major industrialization and innovation support program and a number of small and medium enterprise development activities. Structural reforms described in the Strategy indicate a strong commitment to building a knowledge economy that would drive growth, diversification, and global competitiveness by improving the country's key factor endowments—human capital, infrastructure, and institutions. The Plan of the Nation, with 100 specific steps to implement five institutional reforms,[1] announced by the President in May 2015, outlines a comprehensive reform program and specifies actions to implement the Kazakhstan 2050 Strategy and join the top-30 most-developed countries.

3. **Sustainable and inclusive economic growth, supported by structural reforms, could substantially increase shared prosperity, provided the right reforms are introduced in social sectors, such as health, to improve efficiency, quality, and equity.** At present, high levels of inefficiency in how public sector resources are allocated across social services mean that significant additional budgetary resources are unlikely to be spent effectively. Reforms to rationalize service delivery and distribute resources more equitably are urgently needed, as are reforms to improve the equity and quality of health service delivery.

4. **Health sector reform is also a key component of the Kazakhstan 2050 Strategy, which emphasizes that the "Health of the nation is the basis of our successful future."** Accordingly, the Strategy proposes health care modernization by introducing standards for clinical protocols, medical equipment, and medical supplies across medical institutions to improve the quality of medical services and to increase the health status of the population.

[1] These include (a) formation of the professional state apparatus, (b) rule of law, (c) industrialization and economic growth, (d) identity and unity of the nation, and (e) formation of an accountable state.

5. **"Salamatty Kazakhstan,"** the National Health Strategy, which defined the health priorities for 2011–2015, was adopted by Decree of the President of the Republic of Kazakhstan No. 1113, dated November 29, 2010. Its goal was to improve the health of the people of Kazakhstan to ensure the country's stable sociodemographic development. The program focused on (a) strengthening cross-sectoral and interagency cooperation in matters of the protection of citizens' health and their sanitary-epidemiological well-being; (b) development and improvement of the Unified National Health Care System[2]; and (c) improvement of education in medicine and pharmacology. According to the assessment of the Strategy,[3] almost all the planned activities included in the Strategy were implemented in a timely manner, and several indicators were achieved.

6. **Implementation of a new Health Strategy for 2016–2019 and the design and implementation of a social health insurance scheme are currently top priorities of the Government of Kazakhstan (GoK).** The increasing burden of non-communicable diseases and their associated future health care costs prompted the GoK to increase in its new Health Strategy the focus on cost-effective preventive interventions as part of its guaranteed benefits package and measures to ensure long-term sustainability in health care financing. The GoK also seeks to introduce mandatory social health insurance[4] that would allow for the broad consolidation of funds—which would reflect the principle of "shared responsibility for health" among the state, employers, and employees—in order to cover costs of health services and protect the population from impoverishing out-of-pocket payments.

B. Sectoral and Institutional Context

7. **Kazakhstan is still in the early stages of the demographic transition, and several health indicators are lagging behind those of countries with a similar gross domestic product (GDP) per capita in the region** (Table 1). The proportion of population under 14 years of age decreased from 32 percent in 1990 to 26 percent in 2014, but the proportion of population aged 65 and over increased only 1 percent during this period[5] (from 6 percent to 7 percent). The prevalence of several behavioral-related risk factors for communicable and non-communicable diseases (NCDs) has been reduced. Nevertheless, as Table 1 shows, with the exception of the standardized mortality rate for cancer in the population under 65 years of age, where data show Kazakhstan is not doing poorly compared with other countries, life expectancy is lower (at least seven years lower in males than in comparator countries), while the infant mortality rate and deaths from

[2] Introduced in 2010, the Unified National Health Care System has the following declared principles: (a) free choice by a patient of an inpatient facility for a planned hospital admission; (b) creation of a competitive environment for health service delivery; (c) transparency of the health service delivery process; and (d) financing of health care providers based on final outcome in terms of volume, quality, and efficacy of rendered health services (a move away from cost-estimate-based financing).

[3] The assessment was conducted during October 2014–January 2015 by the World Bank at the request of the Ministry of Health and Social Development in the framework of the Joint Economic Research Program.

[4] The "100 Specific Steps" Plan envisages implementation of a mandatory Social Health Insurance System as a vehicle to strengthen the financial sustainability of the health care system based on shared responsibility of the state, employers, and citizens themselves to prevent and provide early treatment of diseases (step 80).

[5] *World Development Indicators*, World Bank, Washington, DC.

cardiovascular diseases and from cervical cancer, which are easily avoidable, are substantially higher in Kazakhstan.

Table 1: Health Indicators in Selected Countries

	Belarus	Bulgaria	Croatia	Estonia	New EU Members	Hungary	Kazakhstan	Serbia	Eur-A
Real GDP, Thousand PPP$ Per Capita	15.3	16.0	21.0	23.6	21.5	22.0	13.7	11.8	73.0
Life Expectancy at Birth, Males	64.8	70.8	74.0	71.3	72.1	71.7	***63.7***	72.4	78.7
Life Expectancy at Birth, Females	76.6	77.9	80.7	81.4	79.9	78.8	***73.5***	77.5	84.0
Infant Mortality Rate	4.7	7.8	3.6	2.4	5.5	4.9	***16.5***	6.2	3.6
SDR, Cardiovascular Disease < 65	191.3	148.0	60.8	80.6	88.2	92.9	***208.8***	84.7	29.9
SDR, Cancer <65 years	93.1	85.8	90.6	78.6	91.1	***122.4***	85.1	103.2	64.2
SDR, Cancer of the Cervix	5.1	7.3	3.4	7.4	7.7	6.2	8.7	***9.3***	2.1

Source: European Health for All Database (HFA-DB), World Health Organization Regional Office for Europe.
Note: Data are for last available year. New EU members = members since 2014.
EUR-A = Weighted average of 27 EU countries: Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Germany, Greece, Finland, France, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom. Fifteen of these countries are included in the list of the top-30 nations of the 2014–2015 Global Competitiveness Report; http://reports.weforum.org/global-competitiveness-report-2014-2015. SDR = standardized death rate.

8. The top-three causes of disability-adjusted life years (DALYs) in 2010 were ischemic heart disease, cerebrovascular disease, and lower respiratory infections (see Annex 2, figure 1). Among the young population (under 39 years of age), injuries account for more than 70 percent of DALYs. Two causes that appeared in the 10 leading causes of DALYs in 2010 but not in 1990 were chronic obstructive pulmonary disease and cirrhosis of the liver.[6]

9. **The GoK is exploring options to increase revenues flowing to the health sector.** Total expenditure on health in Kazakhstan (3.8 percent of GDP) is well below the average of the Organisation for Economic Co-operation and Development (OECD) countries (9.4 percent of GDP), and the sources of financing are basically government budget and out-of-pocket expenditures, with the latter constituting about a third of total health expenditures.

10. The GoK seeks a progressively higher share of national wealth allocated to health care to reduce the gap with OECD standards. The funding for primary health care (PHC) increased from 16 percent of public health expenditures in 2011 to 21.5 percent in 2014. However, most of the expenditures of the sector remain linked to admissions, where 16 percent of the number of admissions and 18 percent of the total number of inpatient days are due to potentially avoidable hospitalizations.[7] Payment incentives need to be adjusted to increase the incentives to increase ambulatory services and to improve the performance at all levels of the health system.

[6] The "Global Burden of Disease Study 2010" (GBD 2010); http://www.healthdata.org/.
[7] Based on the potential avoidable hospitalizations list of the International Statistical Classification of Diseases (ICD)-10 codes in the database of admissions paid for by the Health Services Payment Committee in 2014.

11. **To increase the quality of service delivery, new standard procedures are being used more frequently in PHC, including the adoption of medical protocols (including diagnosis and treatment) and piloting disease management programs for selected NCDs.**[8] Health facility accreditation procedures are annually conducted by a national body in line with upgraded national standards endorsed by the International Society for Quality in Healthcare (218 health facilities accredited in 2014). Quality improvement is also supported by a reform of the medical education system, and by a new knowledge- and skills-testing system for practicing physicians, graduates of medical universities, and health specialists.[9]

12. **Additional changes in health service delivery are needed to respond to the changing needs of the population and to better support introduction of the social health insurance system.** The adjustment requires implementation of a modern, integrated, patient-centered health system. Technological advances now enable less invasive, earlier, and better diagnosis and treatment, significantly reducing the need for lengthy hospital stays if the health care delivery is properly organized and managed. International experience shows that coping with the new epidemiological profile requires the following: (a) effective health promotion and primary care services that are responsive to local patient needs in a context of integrated health networks; (b) expansion of Disease Management Programs (DMPs) for NCDs; (c) expanded ambulatory secondary specialized services; (d) optimizing inpatient services, services for palliative care for terminally ill patients, and long-term health care for rehabilitation; and (e) developing community-based integrated long-term services for the disabled and elderly.

13. **The GoK seeks to reinforce the principles of social solidarity and collective responsibility in the health sector by introducing a Social Health Insurance (SHI) system.** The expected results of the SHI system are to (a) create a financially sustainable system of mandatory social health insurance financed in a shared manner by all social partners; (b) raise the level of investments in health care to the level of OECD member countries; (c) improve the provider payment mechanisms; (d) ensure accessibility of a social health insurance package for the population; (e) ensure the provision of high-quality health care to the population; (f) by 2030, increase by more than six-fold the provision of the outpatient drug benefit to the population; (g) fully staff the PHC sector with general practice doctors by 2030; (h) improve the efficiency of the health system, based on the priority development of primary health care; and (i) raise the level of health workers' remuneration to the average level of OECD member countries by 2030.[10]

14. **In reintroducing social health insurance, the GoK seeks to learn from the failures of the previous effort.** Between 1996 and 1998, the government introduced Mandatory Health Insurance (MHI). The Mandatory Health Insurance Fund (MHIF) was funded by (a) a 3 percent payroll tax, (b) contributions from the self-employed, and (c) contributions by oblasts for the socially vulnerable groups (for example, children, unemployed, and pensioners). The period was characterized by economic instability, high inflation, and a significant government budget deficit that resulted in high unemployment. In this context, the government and employers failed to fulfill their obligations and, as a result, the total amount of financing covered only 35 to 40 percent of the planned needs. The MHIF collapsed in 1998 due to factors that included (a) many employers

[8] These include hypertension, chronic heart failure, and diabetes.
[9] Specialists must pass this test to be certified, and the certification level/status is being used for payment incentives.
[10] First draft of the Concept of the Kazakhstan Social Health Insurance (SHI) system.

had large debts and could not pay the payroll taxes, (b) the GoK's inability to collect contributions from the self-employed in the large informal sector, (c) failure by oblasts to contribute for the socially vulnerable groups, and (d) mismanagement of the funds. Under the proposed design, considerable attention will be paid to ensuring compliance with contribution payments. Advisory services proposed under this Project includes several activities in this area (see Component 1). The Bank is also providing advisory services.

15. The sectoral and institutional context is now different. The Unified National Health Care System[11] made some progress in improving access and quality in the health sector; and the country's economic growth is relatively strong. The GoK is committed to improving the health of the population, and this goal features prominently in various national and subnational development strategies. The GoK is also committed to the introduction of the new SHI system. The current Ministry of Health and Social Development (MoHSD) has by now gained considerable institutional capacity and experience in health sector reforms, including through implementation of the Bank-funded Kazakhstan Health Sector Technology Transfer and Institutional Reform Project (KHSTTIRP), which has supported two consecutive health sector strategies covering 2005–15.[12]

16. MoHSD also benefited from advisory services on social health insurance design from the World Bank during FY15 and FY16. The Bank has provided advice and guidance based on international experience on issues such as the collection and pooling of revenues, establishment of strategic purchasing arrangements, and the organization of SHI. Also, the Bank has provided extensive comments on the draft SHI legislation and shared examples of SHI legislation from other countries. In FY16, the Bank will provide technical oversight to MoHSD's efforts to produce actuarial costing for the health sector. Managed by the experienced Project Implementation Support Team, the KHSTTIRP also supported the strengthening of technical capacity in the health sector by establishing 10 technical centers/units under the MoHSD-subordinated Republican Center for Health Development (RCHD) (see Annex 6). As MoHSD's technical arm, the overall role of the RCHD is to provide sound technical underpinnings for MoHSD's health strategy and policy formulation function.

17. **The new Health Strategy for 2016–2019 will focus on the cost-effectiveness of preventive interventions;** improving the health services delivery system, with PHC services as a priority; improving the efficiency of human resources management; and implementing measures to ensure the long-term sustainability of health care financing. The strategy also aims to introduce changes in the health financing system that will provide a broad consolidation of funds reflecting the principle of "shared responsibility for health" of the state, employers, and workers to cover the costs of health care services and to protect people from catastrophic expenditure on health.

[11] The concept of the Unified National Health System was introduced in 2010 to support the improvement of health services by strengthening the governance role of the MoHSD, the consolidation of the budget at the national level, introducing patient free choice of providers, implementing quality control procedures, and introducing performance-based payments.

[12] The KHSTTIRP became effective in December 2008 and was extended twice. Activities under four of its components were completed in December 2015, but the project will officially closed in June 2017 when activities under remaining three of its components covered by the second extension are finalized.

C. Higher-Level Objectives to which the Project Contributes

18. **The proposed operation is fully aligned with Kazakhstan's FY2012–17 Country Partnership Strategy (CPS).** The proposed Project would directly support Area of Engagement 2: Strengthening Governance and Improving Efficiency in Public Services Delivery, with a focus on outcome 8: Improving Governance, and outcome 11: Sharpening Strategic Approach to Health Reforms. The intervention and achievements of the ongoing KHSTTIRP have resulted in a strong and sensible policy engagement with the GoK and options (including regional master plans) to increase access to, and quality and efficiency of, health services delivery. The proposed operation will also support Area of Engagement 1: Improving Competitiveness and Fostering Job Creation, by introducing purchasing and provider payment mechanisms that will improve competition and public-private partnership (PPP) options in the health sector. The current Joint Economic Research Program is supporting studies on the design of and options for implementation of a new Social Health Insurance System.

19. The proposed health Project would also contribute to the Bank's Twin Goals by increasing access to higher-quality health care services, especially for the poorest segment of the population, and implementing a solidarity-based social health insurance system that would support a standard package of health service benefits and increase financial protection against catastrophic diseases. The Project would also support implementation of age- and gender-specific protocols and care pathways to contribute to reducing avoidable differences in health status. The health information system will analyze service production and outcome indicators by age and gender.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

20. The proposed Project Development Objective is to improve accessibility, quality, and efficiency of health service delivery, and reduce financial risks to the population that are caused by serious health problems.

Project Beneficiaries

21. The whole population of Kazakhstan, especially its poorest segments, will benefit from improved coverage with higher-quality health care services, and from implementation of a solidarity-based social health insurance system that will support a standard package of health service benefits and increase equity and protection against financial risks caused by serious health problems. The MoHSD and other relevant government agencies, the Social Health Insurance Fund (SHIF), oblast health administrations, medical science education institutions, non-governmental organizations, professional medical and patient associations, and health facilities will benefit from capacity-building activities aimed at running the new financing/payment system.

PDO-Level Results Indicators[13]

[13] Achievement of PDO indicator targets is expected by the end of the Project (Annex 1).

i. Increase public expenditure share for PHC + consultation and diagnostic care[14] + outpatient drugs from 35 percent to 40 percent;

ii. At least 50 percent of all surgeries included in the "outpatient elective surgeries" list paid for by SHIF in the preceding six months were performed as outpatient surgeries in project-supported hospitals and outpatient facilities;

iii. 40 percent of all contracted inpatient services subject to technical audit[15] (annually);

iv. SHIF is fully functional based on predefined criteria[16];

v. A decline from 9.3 to 6.5 percent in the proportion of the bottom 40 percent of households incurring out-of-pocket expenditures on health that exceed 10 percent of total non-food related household spending over a 12-month period.

III. PROJECT DESCRIPTION

22. The proposed Project would support implementation of the national mandatory Social Health Insurance (SHI) system and further adjustments of the Unified National Health System to properly respond to the new population needs and requirements. The SHI system, to be fully operational by 2024, will be introduced under the Concept for Social Development of the Republic of Kazakhstan by 2030, approved by the GoK.[17]

23. The proposed Project has been organized into the following three components: (1) supporting implementation of a national mandatory Social Health Insurance system; (2) strengthening health service delivery to support implementation of the national mandatory Social Health Insurance system; and (3) project management, monitoring and evaluation, and a communications strategy. It is expected that the proposed Project would require 5 years (2017–2021) to be completed, with most of the investment to be implemented in years 3, 4, and 5.

A. Project Components

24. **Component 1. Supporting implementation of the national mandatory Social Health Insurance system (US$16.63 million).** This component would support the design, implementation, and management of the SHI system. Component activities would be divided into two subcomponents.

25. Subcomponent 1.1. Establishing and strengthening the organizational and institutional structure of SHI. The Law on Mandatory Social Health Insurance was passed by Parliament and signed by the President on November 16, 2015, paving the way for the rollout of the national SHI system. The SHI Law creates an entirely new set of institutions, including a Social Health Insurance Fund (SHIF) and accompanying entities, like the Joint Commission on Health Care Quality (JCHCQ), to support the implementation of SHI. The activities proposed under this

[14] Outpatient care.
[15] Technical audit is an audit that seeks to assess adherence of existing practice to diagnostic and treatment protocols, and shall be based on explicit key performance indicators and quality indicators defined by an authorized body.
[16] Predefined criteria as defined in Annex 1 (Indicator Description).
[17] April 24, 2014, No. 396, according to the President's Address to the people of Kazakhstan of January 17, 2014, "Kazakhstan's way – 2050: One goal, common interests, common future."

subcomponent would support the MoHSD in developing and implementing the functions and systems that are critical for the implementation of a SHI program. This subcomponent would support (a) the forecasting of revenues and improving mechanisms for collection of funds within the mandatory SHI system; (b) planning the budget of the mandatory SHI system based on the needs of the population; (c) institutional support for operation of the SHIF; (d) the improvement of health care benefits packages; and (e) the improvement of a SHI information technology system integrated with the e-Health system.

26. Subcomponent 1.2. Strengthening purchasing and payment arrangements under SHI. Kazakhstan has already embarked on wide-ranging purchasing reforms, including provider payment reforms, which are at different stages of implementation. This subcomponent would support the fine-tuning and strengthening of health service purchasing and payment arrangements, and the design and rollout of new reforms, as needed. By supporting these efforts, this subcomponent would contribute to (a) improving the purchasing of health services and provider payment methods; (b) strengthening purchasing of pharmaceuticals and health technologies; and (c) improving financial control mechanisms and technical audits (financial audits, control of amount and quality of rendered services, and so forth) for use by the SHIF.

27. Component 1 would finance advisory services (including twinning[18] contracts), training, goods, services, and operational costs.

28. **Component 2. Strengthening of health service delivery to support implementation of the national mandatory Social Health Insurance system (US$62.94 million).** This component would support the strengthening of population services; primary and secondary prevention; development of the health facility network, including public-private partnerships; improving evidence-based health care delivery; implementation of HTA and effective tools for health services quality management; corporate governance / management in the health sector; development of human resources policy and medical education through strategic partnership with leading academic centers. Component activities would be divided into three subcomponents.

29. Subcomponent 2.1. Developing the health facility network. This subcomponent would support implementation of an integrated network for rendering health care services meeting the current and strategic needs of the population, ensuring the strengthening of public health and the continuity of health care delivery. The subcomponent would (a) facilitate the processes of strengthening public health and formation of a healthy lifestyle, and (b) support restructuring of the network of health care organizations on the basis of master plans, taking into account the priority development of PHC, including the use of PPP mechanisms. The subcomponent would also provide assistance in the coordination of activities for strengthening public health and formation of a healthy lifestyle, integration of PHC functions and epidemiological surveillance. The subcomponent would help improve the processes of monitoring of activities and results of health care delivery to ensure the analytic functions of health care and support policy making that meets the real needs of the population, including the most vulnerable, and public health tasks.

[18] Twinning arrangement is "a process that pairs an organizational entity in a developing country with a similar but more mature entity in another country."

30. Subcomponent 2.2. Managing the quality of health care services. This subcomponent would support the establishment of a comprehensive system of health care services quality management through the standardization of health care, development of HTA, expansion of disease management programs, accreditation of health care organizations, improvement of the formulary system under the JCQHS umbrella, and introduction of corporate governance/management principles for health organizations. The subcomponent would also support the laying of institutional foundations for the functioning of the JCQHS as a platform for developing recommendations on improving of medical education standards, clinical protocols, drug provision, and standards for control over quality and accessibility of health services, with subsequent transformation into a self-regulated organization able to take decisions and to develop, implement, monitor and evaluate regulations in the health care quality, drug supply, and medical science education areas. During implementation of this subcomponent, significant attention would be paid to the maintenance of professional development and to establishing a culture of high ethical principles among the developers of clinical protocols, HTA experts, and reviewers and independent experts; and to the formation of a healthy competitive environment among the providers of health services through involvement of professional medical associations and independent organizations and associations to conduct confidential audits, with subsequent publication of related reports.

31. Subcomponent 2.3. Strengthening of human resources for health care based on strategic partnership. The purpose of this subcomponent is to develop an effective human resources policy for the sector, which ensures the provision of high-quality health care services, through strategic partnerships. This would be achieved by building the key components of the elements of medical education in accordance with the needs of the health system. The following is planned within the framework of this subcomponent: (a) establishment of strategic partnerships with leading academic centers on modernization of medical education; and (b) strengthening of human resources in the health sector. In particular, the subcomponent would support improvement of principles of management and financing of medical education in the transition to the autonomy of education and science organizations; improvement of the education process through introduction of a new policy for admission to medical science education institutions and revision of existing education programs to enable development of physicians' competencies; improvement of the existing system for independent assessment of competencies of medical school graduates and practicing health specialists; and introduction of modern Human Resources (HR) technologies for personnel management. All these would contribute to the high-quality training of health care personnel in the country, focused on the needs of the sector.

32. Component 2 would finance advisory services (including twinning contracts), training, goods, services, and operational costs.

33. **Component 3. Project management, monitoring and evaluation, and communications strategy (US$10.43 million).** This component aims to support a Project Management Unit (PMU) to provide day-to-day project management, including fiduciary and administrative tasks of the Project, as well as monitoring, evaluation, and reporting. The PMU would ensure effective coordination of Project activities with other programs implemented by the MoHSD, other government agencies, and regional authorities.

34. This component would also support a platform of citizen engagement to ensure that the Project fosters openness, feedback, and dialogue with the public. Implementation of the SHI system and the structural reform of health service delivery run the risk of being misunderstood by the various stakeholders affected by them. It is essential that efforts are made to enhance the understanding of all stakeholders, health workers, and the population. The information, education, and communication activities would not only explain the logic behind the changes, but would also explain how these changes would benefit households and communities, including vulnerable communities and women. To ensure the engagement of citizens, the Project would (a) conduct annual multi-stakeholder forums to present updated information and to provide feedback to the MoHSD on the performance of the national SHI system and improvements to the quality of services; (b) develop a community monitoring mechanism to provide qualitative and quantitative feedback and engage providers in responsive actions; and (c) establish a proactive grievance redress mechanism by assessing and strengthening the existing mechanisms for addressing suggestions and complaints from beneficiaries and stakeholders.

35. Component 3 would finance advisory services, communications services, goods, non-consulting services, training, auditing, surveys for project monitoring and evaluation, and equipment and operating costs of the PMU.

B. Project Financing

36. The proposed Project will use an Investment Project Financing instrument (IPF). The use of the Program for Results (PforR) instrument for this Project was discussed given the reforms envisaged. However, the PforR option was discarded and an IPF instrument was considered more appropriate given (a) the GoK's reliance on Bank support for the implementation process; and (b) the Ministry of Education and Science's recent decision with regard to an education project that a PforR instrument could not be used because of national procurement rules. The IPF is appropriate for the proposed operation because it will allow structural investments critical to further implementing the health sector reform. The proposed Project will help finance implementation of short- and medium-term interventions to support the new Health Strategy.

C. Project Cost and Financing

The Project costs and financing are presented in Table 2.

Table 2: Project Costs by Component (in US$ million)

Project Components	Project Cost (US$)	IBRD Financing (US$)	% Financing
1. Supporting implementation of the national mandatory Social Health Insurance system	16.63	14.68	88.25
2. Strengthening of health service delivery to support implementation of the national mandatory Social Health Insurance system	62.94	54.90	87.23
3. Project management, monitoring and evaluation, and communications strategy	10.43	10.42	99.90
Total Costs	90.00	80.00	88.89

Total Financing Required	90.00	80.00	88.89

D. Lessons Learned and Reflected in the Project Design

37. The following are lessons learned from previous and ongoing operations and from international experience:

- Full harmonization of the Bank-financed KHSTTIRP and the health sector strategy proved critical for harnessing strong synergies.
- Simple design is preferable. The KHSTTIRP design covered every major aspect of health reforms and was structured in 7 components and 13 subcomponents. The proposed Project uses only two technical components, which reduces fragmentation and increases flexibility.
- Technical capacity of key technical counterparts needs to be developed (RCHD, SHIF, and so forth), as does the policy and strategic development capacity of the MoHSD.
- The twinning arrangements indicate the need for more careful assessment and selection of twinning partners and for more flexibility in contract provisions to allow for addressing emerging needs of the MoHSD, as may be necessary.
- A well-designed and implemented communications strategy is needed to ensure that the goals, achievements, and experiences of the reform are shared effectively with the professional community and with Kazakhstani citizens to create awareness and build concrete understanding of the process and benefits of the reform.
- The institutional capacity of the many new agencies that are to be created to support social health insurance will require advisory services and Bank's support in the establishment of these agencies. For instance, many of the efficiency and quality improvements expected under the Project would depend on the purchasing agency actually playing the role of a strategic purchaser.
- Sustained and targeted improvements in the quality of PHC require end-users/clients of PHC facilities to engage in the change process. Enhancing access to information (on standards/performance) and integrating feedback mechanisms to health service providers bring about immediate and visible change and help improve the accountability and responsiveness of service providers.

38. Finally, to better define several PDO-level indicators and several intermediate indicators, the proposed Project incorporates indicators and targets suggested in the Universal Health Coverage Monitoring Framework developed jointly by the World Health Organization and the World Bank.[19]

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

39. The MoHSD, as the overarching authority in the health sector, would be responsible for implementation and oversight of the proposed Project. Based on its experience with Bank-funded

[19] "Monitoring progress toward universal health coverage at country and global levels. Framework, measures and targets," World Health Organization and World Bank, May 2014.

projects, MoHSD would develop, steer, coordinate, implement, and monitor Project activities. Other entities to be involved in Project implementation would include MoHSD-subordinated institutions, the SHIF, the JCQHS, local executive bodies in 14 oblasts and in Astana and Almaty cities, and the National Health Care Coordination Council. Greater details on the institutional and implementation arrangement are presented in Annex 3.

40. The Core Coordination Team (CCT) would mirror the same under the KHSTTIRP and be formalized for the proposed Project through a MoHSD order not later than 30 days after the Effectivess Date. The CCT would provide sectoral policy oversight, stewardship of the Project, and working-level coordination with concerned government agencies and regional authorities. All reporting and oversight relationships are summarized in the prepared draft Project Operational Manual (POM) that would be adopted before the Effectiveness Date.

41. The PMU would be enacted through a MoHSD order before the Effectiveness Date based on the Project Implementation Support Team (PIST) functioning under the KHSTTIRP. The PMU would be accountable to the MoHSD and build on the current PIST's experienced human resources whenever possible and warranted.[20] The PMU would be headed by a National Project Coordinator (NPC) and consist of a team of local technical and fiduciary consultants, and a group of support staff (a total of 24 to 25 individuals).[21] Procurement and financial management functions would be fulfilled by local full-time PMU consultants with experience in World Bank procedures. At the same time, efforts to build such capacity within the MoHSD would be continued under the proposed Project.

42. While main consultants of the current PIST would be moved to the new Project's PMU, financing of PMU consultants' fees would follow more streamlined arrangements by flowing directly from the Project funds without being channeled through the MoHSD's contract with its subordinate organization, as is the case under the KHSTTIRP. The CCT members responsible for Project implementation, being core MoHSD staff, would be financed by the GoK through regular salaries, with an adjustment in their work program to allow sufficient time for Project-related tasks. In addition, since the Project represents an integral part of the GoK's new State Health Care Development Program for 2016–2019, the responsibilities of the MoHSD staff under the Project would be essentially the same as their responsibilities for implementation of the new Health Strategy.

43. The SHIF would be established through a GoK decree. It would be both one of the beneficiaries and implementing entities. As the beneficiary, the SHIF would receive advisory services, goods, training, and operational support. As the implementing entity, the SHIF would be involved in the design and implementation of mechanisms, tools, and processes envisaged under the Project (although funding for these activities would be managed by the PMU / MoHSD).

[20] Like the PIST, the PMU would consist of a group of individual consultants hired by and functioning within the MoHSD, with no legal entity establishment required for their functioning. A few core technical and fiduciary staff of the PIST would continue implementation of the KHSTTIRP remaining components until June 30, 2017. Hence, they would also concurrently serve as the core PMU for the proposed Project.

[21] In addition to the NPC, there would be specialists in health insurance, public health, health care quality, medical education and human resources for health, financial management and disbursement, procurement, environmental and social safeguards (as needed). Project assistants, translators, and other administrative personnel would also be engaged on a short-term, as-needed basis.

Institutionally, the SHIF would be a non-profit joint stock company subordinated to the GoK, with the MoHSD represented on the SHIF Board. Operationally, the Chief Executive Officer (CEO) of the SHIF would be a member of the MoHSD CCT for the Project. The JCQHS was established on November 30, 2015 through the MoHSD Order No. 926 titled "On establishment of the Joint Commission on Quality of Health Services" based on the existing Medico-Economic Council. It has the objectives of improving medical education standards, clinical protocols, drug provision, and standards for control over quality and accessibility of health services. Local executive bodies of 14 oblasts and Astana and Almaty cities, being the owners and managers of all state-owned health care providers in their territory, would support the Project by providing or building necessary infrastructure and facilitating implementation of Project activities at the regional level.

B. Results Monitoring and Evaluation

44. Institutional Arrangements for Monitoring and Evaluation. Since the Project represents an integral part of the State Health Care Development Program for 2016–2019, the MoHSD would monitor and evaluate the progress/outcomes of reforms supported by the Project in the context of its overall monitoring of the Program. At the operational level, the responsibility for monitoring and evaluation (M&E) of the Project would rest with assigned staff at the PMU who would collect, analyze, and report M&E data to the MoHSD and the Bank as part of PMU quarterly/annual implementation progress reports. The monitoring data would be reviewed by the CCT and also be used in analytical reports on impact of health sector reforms.

45. Data Sources. To the extent possible, progress on results would be monitored using routine data sources, such as those available from the information systems and administrative records of the MoHSD, its subordinated agencies, the Ministry of Finance (MoF), and the National Bank. In addition, necessary amendments into the periodic data collection instruments (mainly, household health surveys) of the Statistics Committee under the Ministry of National Economy would be introduced. Data on most Project indicators would be reported on an annual basis and, when possible, would be disaggregated by gender and region.

C. Sustainability

46. Implementation of a new Health Strategy for 2016–2019 and the design and implementation of a social health insurance scheme are currently top priorities of the GoK. The proposed Project would cover only a small proportion of investment needed to implement the Regional Master Plans, but would support implementation of the SHI system and some structural changes that would help increase the efficiency of the health sector. Implementation of the Regional Master Plans would require a much larger investment from national, regional, and local resources. Moreover, engagement of clients in processes aimed at PHC improvements has a long-lasting impact.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

47. The Project is transformational by design and includes several innovative elements. As such, it faces a number of risks and issues that need to be addressed. The overall risk to achieving the PDO is rated as "substantial". Key risks are linked to (a) implementation of a totally new health

financing scheme; and (b) implementation of significant reforms in the health service delivery system. The most relevant risks are macroeconomic, sector strategies and technical design, institutional capacity for implementation, fiduciary performance, stakeholders' role, reputational risks, and those related to social safeguards.

48. Risks associated with the macroeconomic context are Substantial. A difficult external economic environment will continue to pose risks to the economic outlook of Kazakhstan. Risks to the short-term outlook may emerge from a further economic slowdown of China and a protracted recession in Russia that affects metal production and metal processing industries in Kazakhstan. Moreover, further softening of oil prices, if the global oil glut persists, may also undermine Kazakhstani consumer and business sentiment and lead GDP to contract. The proposed Project, through its support to the quality of health services and adjustments to the service delivery model would address, to a large extent, the performance and gaps in efficiency at health facilities, including by increasing the use of secondary ambulatory services (day-hospital care and ambulatory surgeries), scaling up disease management programs for NCDs, reducing unnecessary patient referrals between levels of care, and reducing re-admissions. Strategic purchasing under the SHI system would also contribute to reducing fragmentation and improving quality and efficiency. Finally, the Project would further improve medical education and training for health professionals to align the human resources management and capacity development to the new service delivery models supported by the Project.

49. Risks associated with sector strategies, technical design, and stakeholders are Substantial. Implementation of mandatory health insurance will meet with resistance because workers and employers will be required to make direct contributions to finance the SHI system. This will also require that the health services are more responsive as the population increases demand for greater access and higher-quality services. The GoK, with the support of the Project, will continue to make improvements in health service delivery to increase access, efficiency, and quality, and client/patient engagement mechanisms will provide a channel for feedback and action. The studies and advisory services supported by the KHSTTIRP, and the outputs of the Joint Economic Research Program, will help the MoHSD develop a road map and other tools to facilitate Project implementation.

50. The failure of the short-lived mandatory health insurance system of 1996–98 is creating the risk of a prejudiced perception about this new attempt, and might also cause "reform fatigue" among both health professionals and the population at large. The GoK is fully aware of these risks and gives utmost importance to implementing a well-designed and well-targeted communication campaign to ensure transparency and inform the medical community and the population at large about the nature and benefits of these reforms in terms of improving access to and responsiveness of the health system, and the efficiency and quality of health services.

51. Risks associated with institutional capacity for implementation are Substantial. The MoHSD significantly strengthened its institutional capacity with the support of the current KHSTTIRP. The proposed operation will finance twinning arrangements for additional support during implementation of the new SHI system.

52. The risks associated with fiduciary performance are Substantial. There are substantial weaknesses in the overall fiduciary environment, and the principles, including value for money,

transparency, accountability, and participation, are not being fully adhered to. There are usually substantial delays in the approval of budgets and, therefore, in the availability of project funds, project appropriations are often diverted, and there are major weaknesses in data controls in the financial management system, substantially delayed financial reports, weak internal controls and substantive and widespread non-compliance with the core set of rules; weak internal and external audits, and major delays in audit reports and minimal follow-up. In the case of Country Partnership Frameworks (CPFs), the overall fiduciary environment has substantial weaknesses, characterized by low and moderate scores in key diagnostic indicators and recurring fiduciary problems in the Bank portfolio. These risks will be mitigated through the development of a project-specific POM that would document key internal control and other mechanisms to be followed by staff in the application and use of Project funds; developing a module to the existing accounting software that would have the capacity to generate Interim Unaudited Financial Reports (IFRs) and capture the Project's accounts; further building the capacity of the PMU and MoHSD relevant staff in following the Bank's fiduciary requirements; and conducting Bank's fiduciary visits at sufficiently frequent intervals to provide necessary implementation support to the counterparts.

53. Reputational risks associated with the Project are Substantial. The Bank has been closely involved in the design of the new SHI system through the KHSTTIRP and through advisory services. While advice and comments on the draft legislation have been taken into account by the policy makers, in some areas the adopted legislation has overridden technical advice. If policy decisions regarding population coverage and organization of the system itself result in less than adequate performance by the SHIF, the Bank may be criticized for contributing to this. These risks will be mitigated through proactive communication with the GoK, continued close cooperation with the MoHSD, and an open citizen engagement strategy to provide mid-course corrections to the SHI system, as needed.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

54. The Project was designed to help the GoK achieve the goals of efficiency and equity in the health sector, and for the ultimate outcome of improving population health status. The expected economic benefits of the Project include (a) increased efficiency in health spending; (b) improved health status due to improved access (granted by health insurance) and quality of care, especially for prevention and management of NCDs; and (c) reduced impoverishment due to catastrophic health spending, reduced precautionary savings[22] for health, and increased investment in and spending on other economic activities. Given that it is not possible to quantify all economic benefits potentially generated by the Project, the economic analysis presented in Annex 7 would rely partly on qualitative information obtained from an extensive literature review.

55. With this set of conservative assumptions, the net present value (NPV) of DALYs gained due to improving service quality and better access through insurance attributable to the Project is estimated at US$110.9 million for the 5-year period (2017–2021), and US$335.7 million for the 10-year period (2017–2026). The NPV of efficiency gain due to switching some qualified surgeries from inpatient to outpatient is estimated at around US$40.8 million. Taken together, the Project is

[22] Saving that occurs in response to uncertainty regarding future expenditures in health.

estimated to have a benefit-cost ratio of 1.8 using the 5-year time span (2017-2021) or 4.5 using the 10-year horizon (2017-2026). These ratios indicate positive return, even with a high likelihood of underestimating the Project benefits.

B. Technical

56. With the support of the preceding World Bank-financed project (the KHSTTIRP), the GoK has successfully implemented the 2011–2015 National Health Strategy "Salamatty Kazakhstan." The new Health Strategy for 2016–2019 and the design and implementation of a social health insurance scheme are currently top priorities of the GoK. This new strategy is technically sound and aims to address the strategic reform priorities facing Kazakhstan's health sector, that is, increasing access to, and quality of, health services, and increasing financial protection to afford to pay for health care. In this regard, in addition to implementing a National Social Health Insurance System, the strategy seeks to enhance primary and secondary prevention; increase public health services, with a focus on NCDs; increase the emphasis on PHC; implement specialized secondary ambulatory care; support the rationalization of the health facility network; and improve the quality of health care services.

C. Financial Management

57. The Department of Economy and Finance of the MoHSD will be responsible for the financial management (FM) arrangements of the proposed Project. It will be supported by the FM and Disbursement consultants. Overall, the proposed Project will rely on the FM arrangements established for the existing projects implemented by the MoHSD with the support of the PIST. The FM assessment of the MoHSD established that the existing FM systems overall meet World Bank requirements, including budgeting and planning, accounting and financial reporting, flow of funds, internal controls, FM staffing arrangements, and external audit. However, to bring the proposed Project's FM arrangements into full compliance with the Bank's requirements, the MoHSD through the existing PIST that is currently implementing the KHSTTIRP, will (a) document the financial management procedures, including internal controls, in the Financial Management Manual, which is part of the POM, and within the timeline of the POM development; (b) update the TORs for new contracts with the Financial Management Specialist and Disbursement Specialist to reflect responsibilities under the proposed Project; and (c) develop a module to the existing accounting software that has the capacity to generate IFRs and capture the Project's accounts.

58. IFRs will be prepared on a quarterly basis and will be submitted to the World Bank no later than 45 days after the end of each calendar quarter. The formats of the IFRs were agreed upon with the MoHSD during negotiations. The Project accounts will be subject to independent audit on an annual basis. The Project audit report will be made publicly available as per the Access to Information Policy of the World Bank. Detailed FM arrangements are presented in Annex 3.

D. Procurement

59. Procurement of Goods and Non-Consulting services for the proposed Project will be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants," dated January 2011 and

revised July 2014 (Procurement Guidelines); and procurement of Consultant services will be carried out in accordance with the World Bank's "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers," dated January 2011 and revised July 2014 (Consultant Guidelines) and the provisions stipulated in the Loan Agreement. The World Bank's "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants," dated October 15, 2006, and revised January 2011 (Anti-Corruption Guidelines) will apply to this Project. A General Procurement Notice shall be published for the procurements under the Project by the MoHSD.

60. Procurement activities will be carried out by the PMU of the MoHSD. The risk assessment rating for the entire Project will be done through the Procurement Risk Assessment and Management System (P-RAMS). Initial identified risks and proposed mitigation measures are described in Annex 3. The procurement risk is rated as Substantial.

E. Social

61. The Project is expected to have a positive impact on the population; it supports nationwide insurance coverage that will help mitigate the financial risks associated with the financial burden of health expenses. The population will also benefit from improved health care services, including primary and secondary prevention. The main social risk is a lack of public support for the implementation of the new mandatory health insurance reforms. Residents of rural areas, the poor, and self-employed may fear inequality in service provision and a stronger financial burden of insurance costs. Since earlier attempts to introduce a national social health insurance system were unsuccessful, public support for the National SHI, among various population groups, including the most vulnerable, is critical to the success of this Project and uptake of such an initiative.

62. **Citizen engagement.** The Project recognizes that information, education, communication, and two-way feedback and dialogue are key to making the reform work. The Project will incorporate citizens in three ways. First, the Project will conduct a Multi-Stakeholder Forum (MSF) annually. This event will enable the MoHSD to disseminate information about the progress being made, and to hear from citizens about their perceptions of the process and improvements under way. Second, it recognizes that patient feedback is an essential element of enhancing the efficiency and quality of services and includes an awareness-building and patient feedback mechanism on health service providers and facilities. It will be necessary to ensure that capacity building includes improving understanding on the part of health providers of the importance of communication with patients, the benefits of patient feedback, and the accountability of providers to provide citizens with quality health services. Third, the Project will ensure a functioning and proactive grievance redress and feedback mechanism that builds on an existing system in the MoHSD that tracks numbers and types of complaints and resolution. It will also monitor the transparency, credibility, and effectiveness of the grievance redress mechanism (GRM) by users and nonusers. The Project will ensure the engagement of female citizens through these awareness-building and citizen feedback processes.

63. **Gender.** Women are key beneficiaries of the Project, since they constitute 52 percent of the population and coverage is nationwide. In Kazakhstan, life expectancy is 63.7 years for men and 73.5 years for women. While women outlive men, rates of ill health are often higher among women, who experience more health problems and chronic diseases. Moreover, while maternal

mortality is lower in Kazakhstan than in other upper-middle-income countries, the rates of preventable diseases are substantially higher. The Project will support implementation of gender-specific protocols, and gender-disaggregated monitoring of services and care pathways to contribute to reducing avoidable differences in health status. The adopted Social Health Insurance Law specifies the following four groups of people as the first whose health insurance coverage will be subsidized through government contributions: (a) children; (b) mothers with many children;[23] (c) nonworking disabled people; and (d) individuals registered as unemployed. Performance indicators, including the percentage of poor covered by health insurance, will be disaggregated to the extent possible, in order to track gender inequalities in access to services, including primary and secondary prevention, and insurance purchasing capacity. The Project will report gender-disaggregated data for all indicators, where relevant.

64. The Project has no Social Safeguard risks. No new construction is envisaged. However, minor refurbishment and civil works in hospitals and health centers may be undertaken.

F. Environment

65. OP 4.01 Environmental Assessment will not be triggered. All project activities including activities under Component 2 will not relate to and will not lead to generation of medical waste, disposal of old medical equipment and radioactive materials. Thus, the requirements of the Framework Environmental Management Plan (FEMP), which was earlier developed by the Counterpart, do not anymore apply to the Project.

G. Grievance Redress Service

66. Communities and individuals who believe they are adversely affected by a World- Bank-supported project may submit complaints to existing Project-level Grievance Redress Mechanisms or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address Project-related concerns. Project-affected communities and individuals may submit their complaints to the World Bank's independent Inspection Panel, which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

[23] Mothers awarded "Altyn Alka" or "Kumis Alka" pendants or those who had earlier been awarded the title of a heroine mother as well as mothers awarded the order "Mother Glory" of 1st or 2nd degree.

Annex 1: Results Framework and Monitoring

Country: Kazakhstan

Project Name: Social Health Insurance Project: Improving Access, Quality, Efficiency and Financial Protection (P152625)

Results Framework

Project Development Objectives

PDO Statement

The proposed Project Development Objective is to improve accessibility, quality, and efficiency of health service delivery, and reduce financial risks to the population that are caused by serious health problems.

These results are at	Project Level

Project Development Objective Indicators

Indicator Name	Baseline[a]	Cumulative Target Values									
		YR1	YR2	YR3	YR4	YR5	YR6	YR7	YR8	YR9	End Target
1. Increase public expenditure share for PHC + consultation and diagnostic care[24] + outpatient drugs (Percentage)	35.00	35.00	36.00	37.00	38.00	40.00					40.00
2. Percent of all surgeries included in the	5.00	5.00	10.00	25.00	35.00	50.00					50.00

[24] Outpatient care.

"outpatient elective surgeries" list performed as outpatient surgeries in project-supported hospitals and outpatient facilities (Percentage)											
3. Percent of all contracted inpatient services subject to technical audit (annually) (Percentage)	20.00	20.00	25.00	30.00	35.00	40.00					40.00
4. SHIF is fully functional based on predefined criteria[b] (Yes/No)	No	Partial	Partial	Partial	Yes	Yes					Yes
5. Decline in the proportion of the bottom 40% of households incurring out-of-pocket expenditures on health that exceed 10% of total non-food related	9.30 (2013)	9.30	8.50	7.50	7.00	6.50					6.50

household spending over a 12-month period (Percentage)											

Intermediate Results Indicators

Indicator Name	Baseline	Cumulative Target Values									
		YR1	YR2	YR3	YR4	YR5	YR6	YR7	YR8	YR9	End Target
1. Percent of population for whom SHIF received SHI contributions/subsidies and people with access to an insurance package of health services[c] (Percentage/million[c])	0.00	0.00 / 0.00	40.00 / 7.00	50.00 / 8.80	55.00 / 9.60	60.00 / 10.50					60.00 / 10.50
2. Achievement of key benchmarks for functioning social health insurance system (Yes/No)	No	Plan and benchmarks defined	Partial	Partial	Yes	Yes					Yes
3. Key adjustments in the contracting methods are	No	No	Yes	Yes	Yes	Yes					Yes

adopted to include incentives for providers to improve quality (Yes/No)											
4. Number of fully functional regional PHC excellence centers (Number[d])	0.00	0.00	0.00	5.00	10.00	16.00					16.00
5. Number of regions implementing disease management programs with evidence-based effectiveness, including incentives for health providers and patients[e] (Number)	2.00	2.00	7.00	10.00	13.00	16.00					16.00
6. Percent of health facilities meeting International Patient Safety Goals (minimum 5 points) (Percentage)	10.00 (2014)	15.00	20.00	30.00	40.00	50.00					50.00

7. Number of educational programs developed and implemented in medical education institutions based on competence-based approach and professional standards through strategic partnerships (Number)	1.00	2.00	3.00	4.00	4.00	5.00					5.00
8. Unified register of human resources for health implemented (Yes/No)	No	No	No	No	Yes	Yes					Yes
9. Direct project beneficiaries (Number) - (Core)	0.00	100.00	1700.00	5000.0	8200.00	10000.0					10000.00
9.a. Female beneficiaries (Percentage - Sub-Type: Supplemental) - (Core)	0.00	52.00	52.00	52.00	52.00	52.00					52.00
10. Health personnel	0.00	90.00	900.00	1900.00	2800.00	3400.00					3400.00

receiving training (number) (Number) - (Core)											
11. Health facilities constructed, renovated, and/or equipped (number) (Number) - (Core)	0.00	0.00	10.00	20.00	50.00	50.00					50.00
12. Percentage of patients reporting improved health services[f] (Percentage)	50.00	50.00	50.00	55.00	60.00	70.00					70.00
13. Increase in transparency, credibility, and effectiveness of the complaints handling system (Percentage)	0.00	20.00	30.00	35.00	40.00	60.00					60.00

Note

a. Baseline is indicated for 2015 (the most recent data available), unless otherwise stated.
b. List of criteria is specified in the Table "Indicator Descriptions."
c. IRI 1: information will be disaggregated by region and gender.
d. Existing information system for monitoring of implementation of budgetary investment projects.
e. IRI 5: This indicator has reference to the health services coverage indicator "coverage with a set of tracer interventions for treatment services" from the Universal Health Coverage Monitoring Framework developed jointly by the World Health Organization and the World Bank ("Monitoring progress towards universal health coverage at country and global levels. Framework, measures and targets," World Health Organization and World Bank, May 2014.)
f. IRI 12: information for years 4 and 5 will be disaggregated by region and gender.

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
1. Increase public expenditure share for PHC + consultation and diagnostic care + outpatient drugs	Numerator: Total public expenditure (including SHI) financing PHC, consultation and diagnostic (outpatient) care, and outpatient drugs x 100 Denominator: total public expenditure (including SHI)	Annually	National Health Accounts, information on execution of state budget from MoF, routine reporting of SHIF	PMU, SHIF
2. Percent of all surgeries included in the "outpatient elective surgeries" list performed as outpatient surgeries in project-supported hospitals and outpatient facilities	Numerator: Number of surgeries included in the "outpatient elective surgeries" list[a] paid by SHIF in the preceding six months that were performed as outpatient surgeries in hospitals receiving project support under Component 2. Denominator: Total number of surgeries included in the "outpatient elective surgeries" list[a] in hospitals receiving project support under Component 2 paid by SHIF in the preceding six months.	Annually	Semiannual reports from SHIF billing information system	PMU, SHIF
3. Percent of all contracted inpatient services subject to technical audit (annually)	Numerator: Number of contracted inpatient services subject to technical audit in the preceding calendar year. Denominator: Total number of contracted inpatient services in the preceding calendar year. Technical audit mechanisms will be continuously updated with support from Subcomponent 1.2.	Annually	Annual reports from SHIF billing information system	PMU, SHIF
4. SHIF is fully functional based on predefined criteria	The following Yes/No criteria should be satisfied to consider SHIF fully functional:	Annually	Project Monitoring Reports, financial data from MoF, and financial audit reports	PMU, DF

	i) Law on Social Health Insurance is adopted, and relevant by-laws are updated ii) SHIF signs contracts with providers for specific sets of services iii) Insurance package is defined and approved iv) SHIF undergoes annual external financial audits v) SHIF has positive balance between revenues and expenses vi) Health facilities receive payments for services contracted by SHIF in accordance with payment schedules specified in their contracts.			
5. Decline in the proportion of the bottom 40% of households incurring out-of-pocket expenditures on health that exceed 10% of total non-food related household spending over a 12-month period	Numerator: Number of the bottom 40% of households incurring out-of-pocket expenditures on health that exceed 10% of total non-food related household spending over a 12-month period. Denominator: Total number of the bottom 40% of households.	Annually	Household Survey	PMU, SHIF, Statistics Committee of the Ministry of National Economy

Intermediate Results Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
1. Percent of population for whom SHIF received SHI contributions/subsidies and people with access to an insurance package of health services	Numerator: Number of persons for whom SHIF received SHI contributions or state-paid subsidies in the preceding calendar year in full; Denominator: Total resident population. Resident population will be taken from the civil registry held at the Ministry of Justice/Statistics Committee.	Annually	SHIF information system	PMU, SHIF

	The second part of this indicator is a Core Sector Indicator. For the purpose of this indicator, the access to an insurance package of health services is as defined in the Law of the Republic of Kazakhstan No. 405-V-3PK dated November 16, 2015 "On mandatory social health insurance".			
2. Achievement of key benchmarks for functioning social health insurance system	Year 1: An implementation plan for the SHI is defined, including benchmarks. Years 2 to 5: Some/all benchmarks are being achieved as planned.	Annually	SHIF reports, Project Monitoring Reports	PMU, SHIF
3. Key adjustments in the contracting methods are adopted to include incentives for providers to improve quality	Contracting methods for PHC, ambulatory services, and inpatient services incorporate incentives based on quality and performance.	Annually	SHIF reports, Project Monitoring Reports	PMU, SHIF
4. Number of fully functional regional PHC excellence centers	Number of established regional PHC excellence centers satisfying following yes/no benchmarks before or during the target year: i) PHC excellence center is staffed with general practice physicians; ii) General Practitioners (GP) offices are equipped in accordance with MoHSD-approved standards; iii) PHC excellence center implements disease management programs; iv) PHC performs as a training center for PHC HR.	Annually	Project Monitoring Reports	PMU, DHSO
5. Number of regions implementing disease management programs with evidence-based effectiveness, including incentives for health providers and patients	Number of regions where PHC organizations implement disease management programs and achieve the following DMP indicators: i) At least 70% of patients participating in DMPs on arterial	Annually	Project Monitoring Reports	PMU, DHSO

	hypertension have the level of arterial tension (AT) ≤140/90; ii) At least once a year, low-density lipoprotein (LDL) level is measured in patients participating in DMPs on chronic heart failure; iii) At least once a year, glycated hemoglobin (HbA1c) level is measured in patients participating in DMPs on diabetes mellitus.			
6. Percent of health facilities meeting International Patient Safety Goals (minimum 5 points)	All health facilities participating in accreditation will fill out in the Quality Management (Information) System for Health Organizations the section on patient safety, which has 6 International Patient Safety Goals (IPSGs): i) Correct identification of patients ii) Ensuring effective sharing and use of information among health workers iii) Safe use of pharmaceuticals with high degree of risk iv) Verification of correct body part for surgical intervention v) Hands hygiene vi) Prevention of patient falls. One point is given for achieving each of the listed goals. A total of 5 points is the minimum threshold for certifying a health facility as meeting IPSGs.	Annually	Quality Management (Information) System for Health Organizations	PMU, CCMPA
7. Number of educational programs, developed and implemented in medical education institutions based on competence-based approach and professional	Number of educational programs, developed and implemented in medical education institutions based on competence-based approach and professional standards through strategic partnerships.	Annually	MoHSD Orders on approval of developed programs, Project Monitoring Reports	PMU, DSHR

standards through strategic partnerships				
8. Unified register of human resources for health implemented	Unified register will have information on key professional features and professional areas of health workers: employer organization, work experience, availability of degrees, and qualifications.	Annually	Project Monitoring Reports	PMU, DSHR, MoHSD Department of Informatization
9. Direct project beneficiaries	Core Sector Indicator. Direct beneficiaries are people or groups who directly derive benefits from an intervention. For the purpose of this indicator, direct project beneficiaries are: health workers and staff of pilot organizations involved in Project implementation (in cumulative terms).	Annually	Project Monitoring Reports	PMU
9.a. Female beneficiaries	Core Sector Indicator. Based on the assessment and definition of direct project beneficiaries, specify what percentage of the beneficiaries are female.	Annually	Project Monitoring Reports	PMU
10. Health personnel receiving training (number)	Core Sector Indicator. This indicator measures the cumulative number of health personnel receiving training through a Bank-financed project.	Annually	Project Monitoring Reports	PMU
11. Health facilities constructed, renovated, and/or equipped (number)	Core Sector Indicator. This indicator measures the cumulative number of health facilities constructed, renovated and/or equipped through a Bank-financed project.	Annually	Project Monitoring Reports	PMU
12. Percentage of patients reporting improved health services	Citizen Engagement Indicator. Data to be produced by a sample community scorecard: Methodology to be designed and completed in Year 1. First baseline with new methodology is expected in Year 2. Information for years 4 and 5 will be disaggregated by region and gender.	Annually	Annual scorecard, disaggregated by PHC, hospitals, gender, etc.	PMU

13. Increase in transparency, credibility, and effectiveness of the complaints handling system	Citizen Engagement Indicator. Numerator: Number of surveyed patients who report awareness of the grievance redress mechanism, greater transparency and credibility of the grievance redress mechanism; and used/are likely to use it in the event of a complaint. Denominator: Total number of patients surveyed through a representative sample.	Annually	Annual scorecard	PMU

Note:
For IRI 1 and IRI 12, information will be disaggregated by region and gender.
a. Cataract removal, laparascopic removal of inguinal hernia, surgeries on funicle varicocele and hydrocele, hysteroscopy, removal of osteosynthetic devices, bone biopsies.

Annex 2: Detailed Project Description

KAZAKHSTAN

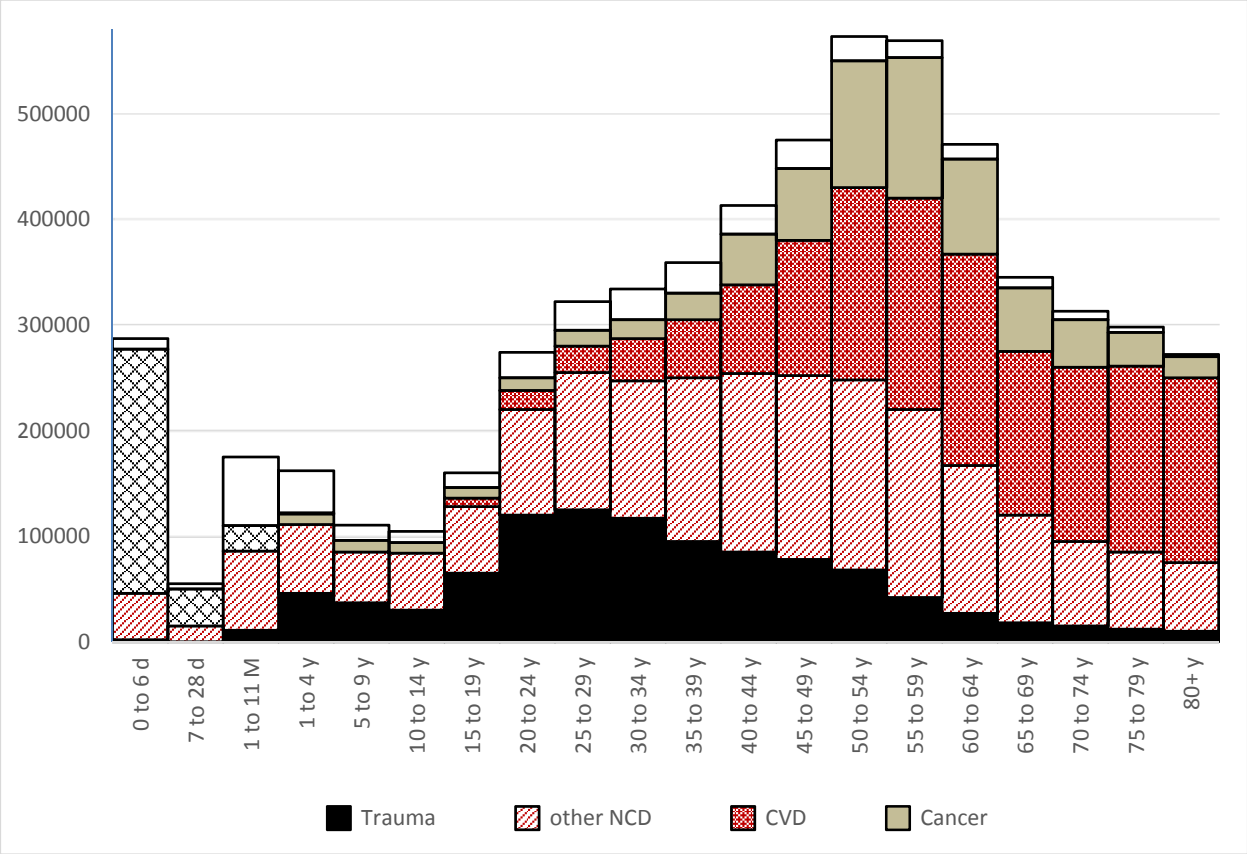
Social Health Insurance Project:
Improving Access, Quality, Efficiency, and Financial Protection (P152625)

1. **Kazakhstan is still is in the early stages of the demographic transition, and several health indicators are lagging behind those of countries with a similar gross domestic product (GDP) per capita in the region.** The proportion of the population under 14 years of age decreased from 32 percent in 1990 to 26 percent in 2014, but the proportion of the population aged 65 and over increased only 1 percent during this period[25] (from 6 percent to 7 percent).

2. The top three causes of disability-adjusted life years (DALYs) in 2010 were ischemic heart disease, cerebrovascular disease, and lower respiratory infections (figure A2.1). Among the young population (under 39 years of age) injuries accounts for more than 70 percent of DALYs. Two causes that appeared in the 10 leading causes of DALYs in 2010 and not in 1990 were chronic obstructive pulmonary disease and cirrhosis of the liver.[26]

[25] *World Development Indicators*, World Bank, Washington, DC.
[26] "The Global Burden of Disease Study 2010" (GBD 2010); http://www.healthdata.org/.

Figure A2.1. Kazakhstan DALYs by cause and age, 2010



Source: "The Global Burden of Disease Study 2010" (GBD 2010); http://www.healthdata.org.

3. **The new Health Strategy for 2016 to 2019** will focus on expanding the implementation of cost-effective preventive interventions; improving the health services delivery system, with PHC services as a priority; improving the efficiency of human resources management; and implementing measures to ensure the long-term sustainability of health care financing. The strategy also aims to introduce changes in the health financing system that will provide a broad consolidation of funds reflecting the principle of "shared responsibility for health" of the state, employers, and workers to cover the costs of health care services and to protect people from catastrophic expenditure on health.

4. Effectively and efficiently adjusting health service delivery to the new health care needs of the Kazakhstani population requires a modern, integrated, patient-centered health system. Technological advances now enable less invasive, earlier, and better diagnosis and treatment, significantly reducing the need for lengthy hospital admissions if the system is properly structured and governed. International experience shows that coping with the new epidemiological profile requires the following:

a. Effective health promotion (population services) and primary care services in a context of integrated health networks. These services play an important part in reducing the

incidence of current health problems, increasing early detection, managing the bulk of routine conditions, and acting as an effective gatekeeper in patient access to referral care. The implementation of integrated networks aims to solve the current problems of fragmentation of services and promote the "navigation" of patients through the different levels of care and allow greater continuity of health care. Tools for implementing clinical guidelines need to be developed to put together protocols, algorithms, and care pathways for patients defining the health care interventions to be implemented in each level of care (primary, secondary or tertiary) to the most common health conditions.

b. Expansion of Disease Management Programs (DMPs). To deal with the increasing burden of NCDs, Kazakhstan needs a progressive expansion of the DMPs from primary care and in the context of the integrated networks. The DMPs constitute a system of coordinated health interventions for patients with specific conditions in which self-care efforts are significant. The programs are based on a process of the transfer of knowledge and empowerment in which communication between patient and health professionals (and if necessary the patient's family) plays a central role in developing a plan of care that seeks to prevent or reduce the negative effects of chronic diseases.

c. Expanded ambulatory secondary specialized services, to introduce high-resolution ambulatory diagnostic and treatment schemes for higher-volume, lower-cost specialized services, including ambulatory surgeries, day care, and specialized care for complications resulting from chronic conditions. These centers could operate as independent entities or as satellite units of hospitals, allowing sharing of human resources.

d. Optimizing inpatient services, services for palliative care for terminally ill patients, and long-term health care for rehabilitation. The differentiation of roles across these services should emphasize the delivery of quality services in an inpatient regime in a cost-effective manner, with the best mix of technology and human resources inputs, differentiating general hospital "secondary" services from "true tertiary care," high-complexity hospitals, as necessary. A product of the fragmented evolution of the hospitals is that they independently evolved with a production of a mixture of services for acute and subacute care, and lengthy hospitalization. This affects production and cost of services, because the human resources, the type of equipment, and structural characteristics of the services should be very different for each of these types of cases. In the context of integrated networks, better distribution of the roles of hospitals would allow a better allocation of cases by type of care needed. For example, patients who no longer require acute complex care could be transferred to subacute services, freeing beds that could be used for patients who require more intensive care. Thus, if a patient could not be discharged after a surgical procedure because the conditions of his or her family support do not allow home management and require a few days of hospitalization, a move to a subacute care unit would allow the acute care hospital to continue to perform needed surgeries and, thereby, reduce the waiting list for elective surgery. Similarly, patients requiring prolonged hospitalization or palliative care can receive more appropriate services under conditions specific to their needs.

e. Developing community-based integrated long-term services for the disabled and elderly. It would be preferable if Kazakhstan did not take an overly institutional route to providing long-term care.

5. **Changes in the governance of the health system could also increase efficiency and quality.** Further development of heath technology assessment and quality management mechanisms would also support the efficiency and sustainability of the system.

6. Managers should have expertise and greater regulatory flexibility to manage the effective provision of health services, including options to contract services instead of paying for salaries, to negotiate individual salaries for key staff, with no restrictions imposed on hiring, allowing them to more effectively respond to client feedback and local needs. Collaborative work should be encouraged, allowing model adjustments toward increasing the effectiveness and efficiency of the health network.

Proposed Project Components

7. The proposed Project would support implementation of the National Mandatory Social Health Insurance (SHI) system and further adjustments of the Unified National Health System to properly respond to the new population needs and requirements. The SHI system, to be fully operational by 2024, will be introduced under the Concept for Social Development of the Republic of Kazakhstan by 2030, approved by the GoK.[27]

8. The proposed Project will use an Investment Project Financing instrument. Potential use of a Program-for-Results-type component was discussed, and discarded at the request of the GoK. All the activities have been organized into the following three components: (1) support for implementation of a national mandatory social health insurance system; (2) introduction of reforms to improve access, quality, and efficiency of health service delivery alongside the introduction of a national Social Health Insurance system; and (3) project management, monitoring and evaluation, and communications strategy. The proposed Project is projected to require 5 years (2017–2021) to be completed, with most of the investment to be implemented in years 3, 4, and 5.

9. **Component 1. Supporting implementation of the national mandatory Social Health Insurance system (US$16.63 million).** This component would support the design, implementation, and management of the SHI system. Component activities would be divided into two subcomponents:

(a) Subcomponent 1.1. Establishing and strengthening the organizational and institutional structure of the mandatory SHI. The SHI Law was passed by the Parliament and signed by the President on November 16, 2015, paving the way for the rollout of the national SHI system. The SHI Law creates an entirely new set of institutions, including a Social Health Insurance Fund (SHIF) and accompanying entities, like the Joint Commission on Health Care Quality, to support the implementation of SHI. The activities proposed under this subcomponent would support the Ministry of Health and Social Development (MoHSD) in developing and

[27] April 24, 2014, No. 396, according to the President's Address to the people of Kazakhstan of January 17, 2014, "Kazakhstan's way – 2050: One goal, common interests, common future."

implementing the functions and systems that are critical for the implementation of a SHI program.

The establishment of a clearly defined SHI structure to collect, record, manage, and pool funds and purchase health care goods and services is essential for the success of the proposed SHI system. By supporting these efforts, this subcomponent would contribute to:

- Introducing the mandatory SHI system, mechanisms of financial consolidation, and management functions at the regional and national level;
- Ensuring effective management and operation of SHIF;
- Improving health care benefits packages;
- Developing a SHI information technology system integrated with the e-Health system.

Under this subcomponent, regular studies on revenue forecasting would be conducted; alternative sources of funding for health would be explored; recurrent updates of actuarial projections would be facilitated; and improvement of the national health accounts system would be supported based on the System of Health Accounts 2011 (SHA 2.0).

Plan of the key activities.

a. Forecasting revenues and improving mechanisms for collection of funds within the mandatory SHI system. The Project would finance advisory services, methodological support, and capacity building in the areas of (a) regular assessment of income of the self-employed population, including groups of people employed in the informal sector; (b) identification, evaluation, and implementation of best international practices in health financing from alternative sources, such as fees or special trust funds from taxation of unhealthy foods and products, co-payments, and so forth; (c) regular assessment of the revenues generated from the formal sector of the economy (large and medium enterprises, individual entrepreneurs, etc.); and (d) forecasting revenue coming from the state budget to finance contributions for the socially vulnerable groups and citizens exempt from making contributions to the mandatory SHI.

b. Planning the budget of the mandatory SHI system based on population needs. The Project would finance advisory services, methodological support, and capacity building in the area of budget planning of the mandatory SHI system based on the needs of the population. This work would include development of necessary methodologies, conduct of research on the prevalence of disease, and assessment of the health needs of the population of different regions. This activity would be based on regular actuarial calculations, and an estimation of per capita budget allocation for different gender and age groups and epidemiological profiles.

c. Institutional support for operation of the SHIF. The Project would provide advisory services, methodological support, and capacity building for developing the Fund strategy, establishing best practices for managing the SHIF, income planning, financial management, and development of monitoring, evaluation and reporting systems at both the national and regional level.

d. Improving health care benefits packages (BP). The Project would finance advisory services, methodological support, and capacity building in improving the list of health services, namely with regard to (a) establishing a transparent and evidence-based process of selection of the most effective medical services and drugs to include in the BP; (b) ensuring fair pricing through the calculation of service and drug costs included in the BP; (c) establishing required mathematical models and tools for calculating the cost of the BP; and (d) providing recommendations on the terms and frequency of care and drug provision included in the BP. This activity would be informed by the studies on population needs assessment in health technologies and services, and budget planning carried out within this subcomponent.

e. Improving a SHI information technology system integrated with the e-Health system that has already been established will be critical for the successful implementation of SHI. This would include a) developing a strategy for building information and communication infrastructure of mandatory social health insurance; b) developing mechanisms for integration of the information system of mandatory social health insurance with other stakeholder information systems, including e-Health systems; c) making improvements to the e-Health system to ensure its functionality under the mandatory social health insurance conditions; and (d) setting up a registry of individuals entitled to receive health care under the mandatory SHI. The registry would be the foundation for all other systems to be implemented. Since this registry would be created for the purpose of the health insurance system, the SHIF would face a one-time challenge of ensuring data accuracy and completeness, and eliminating any duplicate records. The Project would support activities and information systems tools to support this process, working closely with the Ministry of National Economy and the Committee of State Revenues of the Ministry of Finance, who would determine the contributions of the employed population, and the subsidized contributions for those with no or limited capacity to pay, and of the socially vulnerable and exempted population.

(b) Subcomponent 1.2. Strengthening purchasing and payment arrangements under mandatory SHI system. Kazakhstan has already embarked on wide-ranging purchasing reforms, including provider payment reforms that are at different stages of implementation. This subcomponent would support the fine-tuning and strengthening of health service purchasing and payment arrangements and the design and rollout of new reforms as needed. By supporting these efforts, this subcomponent would contribute to:

- Improving the purchasing of health services and provider payment methods;
- Strengthening purchasing of pharmaceuticals and health technologies;
- Improving financial control mechanisms and technical audits (financial audits, control of amount and quality of rendered services, and so forth) for use by the SHIF.

Health care provider payment systems—the way providers are paid to deliver the covered package of services—are an important strategic lever for balancing system revenues and costs in a way that creates incentives for providers to improve quality and deliver services more efficiently. This ultimately makes it possible to expand coverage within limited funds. Meanwhile, strategic purchasing is a lever to direct limited funds to priority services and

populations more effectively. A single payer, as would be the case with the proposed SHIF, has significant potential to become a strategic purchaser provided steps are taken to develop strategic purchasing capacity early on. Therefore, this subcomponent would directly contribute to increasing technical and allocative efficiency in service provision by implementing provider payment mechanisms that promote the provision of primary care health services and coordination of care, strengthening mechanisms for purchasing pharmaceuticals, and enabling the SHIF to become a strategic purchaser of services.

Under this subcomponent, the following reforms would be designed and piloted in a subset of oblasts during the first two to three years of the Project. Financing for the national rollout of these reforms would be considered under the Project following careful evaluation of the pilots and their outcomes.

Plan of the key activities:

a. Improving the purchasing of health services and provider payment methods. This activity would finance advisory services, methodological support, and capacity building to improve provider payment mechanisms through (a) strengthening the processes for selecting providers, given the priorities in health development and the introduction of planned incentives for private sector development; (b) development and improvement of contracts for health care providers at various levels, taking into account quality indicators and other incentives, as well as procedures for the conduct of negotiations with health care providers; (c) further improvement of PHC payment methods for consultative and diagnostic services, inpatient and substitute care, and other types and forms of care, based on internationally recognized classifications, taking into account development priorities of health, and implementation of planned incentives for the private sector; and (d) improving the remuneration methods for health workers, thereby incentivizing them to improve their job performance.

   Specifically with regard to PHC, this activity would support capacity building in the SHIF to enter into performance agreements with primary care providers, with a focus on equitable access to care and improvement in quality. It is anticipated that capitation-based performance payments that would be provided according to terms of the performance agreements with providers would motivate facility staff to improve access to services and increase quality of care. Activities would include supporting the SHIF in developing and finalizing the necessary administrative regulations and by-laws to implement performance agreements, verification, and payments; designing key parameters for the strategic purchasing of primary care services, such as performance indicators, contract monitoring and payment terms, standard operating procedures for the implementation of performance agreements, and so forth, and building the capacity of SHIF and other SHI bodies to effectively carry out the strategic purchasing function, including monitoring performance, identifying problems and issues, making payments, and planning and budgeting methodology; building the capacity of providers to measure, report on, and improve performance; and financing an annual independent technical audit to be implemented by an external firm to verify the number of beneficiaries of the capitation-based performance payments, verification that the agreed performance targets have been achieved, and to check whether capitation-based performance payments were calculated correctly.

Specifically with regard to hospital care services, this activity would finance refining and expanding the existing DRG payment mechanisms, and gradual introduction of other hospital payment methods that stimulate improvements in effectiveness of chronic diseases management and health care integration.

b. Strengthening the purchasing of pharmaceuticals including (a) introduction of external reference pricing (comparing the prices of drugs in Kazakhstan to the prices paid in other countries[28]); (b) internal reference pricing (comparing the prices of drugs of similar effectiveness[29]); (c) development of a copayment policy to promote the use of generic drugs; (d) establishment of an efficient, transparent, and predictable reimbursement process as well as introduction of mechanisms to promote the use of generic drugs; and (d) adoption of measures for the introduction of managed Entry Agreements.[30]

c. Improving financial control mechanisms and technical audits within the mandatory SHI system. SHIF performance of functions of strategic purchaser would require creation of effective methods of control over the activities of care providers, and implementing financial control tools. The Project would finance advisory services, methodological support, and capacity building in the (i) development and implementation of effective tools of the technical audit of health providers; (ii) development and implementation of billing and processing and other payment mechanisms; (iii) establishment of a system of internal financial controls in the SHIF; and (iv) evaluation of the quality of care and achieving planned outcomes and quality indicators by health care providers.

10. Component 1 would finance advisory services and methodological support (including twinning contracts), training, goods, and services.

11. **Component 2. Strengthening of health service delivery to support implementation of the national mandatory Social Health Insurance system (US$62.94 million).** This component would support the strengthening of population services; primary and secondary prevention; development of the health facility network, including public-private partnerships; improving evidence-based health care delivery; implementation of Health Technology Assessment and effective tools for health services quality management; corporate governance / management in the health sector; development of human resources policy and medical education through strategic partnership with leading academic centers. The component would also facilitate adaptation of the health care delivery system to functioning under the mandatory social health insurance system and ensuring an increase in efficiency of health spending by exerting influence on rendered health care. Component activities would be divided into three subcomponents:

(a) Subcomponent 2.1. Developing the health facility network. This subcomponent would support implementation of an integrated network for rendering health care services and a health care delivery system meeting the current and strategic needs of the population, ensuring the strengthening of public health and the continuity of health care delivery. The subcomponent would (a) facilitate the processes of strengthening public health and formation of a healthy lifestyle; and (b) support restructuring of the network of health care organizations on the basis

[28] All EU countries except the UK use this methodology.
[29] Most EU countries use this methodology.
[30] All EU countries use these for negotiating prices of innovative expensive drugs.

of master plans, taking into account the priority development of primary health care (PHC), including the use of public-private partnership mechanisms.

The subcomponent would provide assistance in the coordination of activities for strengthening public health and formation of a healthy lifestyle, integration of PHC functions and epidemiological surveillance. The subcomponent would help improve the processes of monitoring of activities and results of health care delivery to ensure analytic functions of health care and support policy making that meets the real needs of the population, including the most vulnerable, and public health tasks.

The subcomponent activities would cover various aspects of the health service delivery network development, including ensuring physical accessibility of health care, availability of human and material resources, quality of health care delivery, relevance of care rendered, timeliness and continuity of care delivery, social responsibility of health care providers and patients, including public-private partnership mechanisms.

The restructuring of the network and improvement of the health care delivery system would allow improvement in the efficiency of the funds spent on the provision of the guaranteed volume of free health care (GVFHC) by reducing duplication of services among levels and forms of care, and reorientation of material and human resources to the relevant nosologies[31] and cost-effective types of health care services. The development of measures for the protection of public health and the formation of a healthy lifestyle would ensure a reduction of the impact of risk factors on the incidence rate of NCDs. PHC development and optimization of the stock of inpatient hospitals would allow an improvement in the availability, and at the same time, make the transition to less costly forms of health care delivery for a greater number of diseases and patients. Introduction of an integrated approach of a PHC physician to health care of a patient would allow the introduction of efficient and cost-effective methods of control and prevention of NCDs. Centralization of secondary care, including clinical and diagnostic laboratories, would ensure the efficiency and profitability of expensive and high-tech services. Implementation of PPP mechanisms in the process of restructuring of the network would provide an inflow of private investment, reducing the burden on national and local budgets.

The total effect of the subcomponent realization in the medium and long term would be expressed in reduction of the morbidity associated with behavioral and manageable factors, reduction of the number of complications in chronic conditions, and an overall decline in the disease burden. Health improvement of the population entails curbing the growth of health care costs associated with a change in the demographic situation and the rising cost of health technologies, and an increase of the share of the working population, implying an increase in tax deductions and a reduction of costs associated with social support.

Plan of the key activities:

1. Establishment of a Public Health Service. Increase promotion of a healthy lifestyle and reduce risk factors for NCDs, and strengthen the epidemiological surveillance system

for outbreaks and capacity building for policy planning in the field of public health and the organization of the health services delivery system. Main activities would be the following:

a. Development and introduction of long-term interdepartmental strategies of informing the population about and involving them in health care and the formation of a healthy lifestyle based on a comprehensive study of behavioral risk factors. Introduction of modern technologies on the promotion of a healthy lifestyle at the individual, group, and population level. Development of inter-sectoral collaboration of central and local bodies on health care, development of healthy lifestyle and behaviors reducing the prevalence of risk factors.

b. Support of the Public Health System to strengthen monitoring and epidemiological surveillance of the risk factors and non-communicable and communicable nosologies with highest disease burden. Support the coordination of activities on public health issues, including promotion of a healthy lifestyle, management of non-communicable diseases (NCD), healthy nutrition, environment, physical activity, etc.

c. Conduct comprehensive epidemiological studies in terms of regions and/or individual health issues to explore the specificity of cause-effect mechanisms of NCDs.

d. Improvement of the management of health information, ensuring institutional capacity necessary for data analysis and the generation of information and knowledge, and for making informed policy decisions. Study and definition of priorities in public health protection based on best international practice in the epidemiology of communicable and non-communicable diseases.

e. Development/improvement of a regulatory framework and specialized programs, with the aim of the provision of quality and safe food, and the prevention of alimentary-dependent diseases and conditions. Support to the Codex Alimentarius national intersectional coordination council activity.

f. Assistance in the conduct of activities for involving citizens in the protection of their own health and formation of a healthy lifestyle.

2. Assistance in improving primary and secondary prevention and strengthening primary health care services. Enhancing focus on the management of NCDs and performance-based services. Main activities would be the following:

    a. Support to the processes of further development of PHC based on family medicine principles and multi-disciplinary approach. Support to development of PHC standards based on experience of strategic partners, including requirements for facilities, equipment, staffing, introduction of a quality management system, and patient flow management.

b. Modelling of a health service delivery system with emphasis on strengthening the role of PHC and respective redistribution of functions among the forms and types of service delivery. Support to the process of PHC integration with vertical specialized services (psychiatric services, addiction treatment services, tuberculosis services, oncological services, and so forth), and ensuring continuity of health care delivery.

c. Improvement of primary and secondary prevention of diseases at the PHC level, including immunization and epidemiology activities, and interaction with specialized services. Improving the National Screening Program through the optimization of the list of screenings based on their effectiveness with different target groups of population. Development of an algorithm for preventive activities of PHC workers for identification of individual risk factors for NCDs, and determination of a model of preventive intervention and its evaluation.

d. Assistance in establishing and ensuring sustainability of PHC Centers of Excellence in each oblast and republican-level city, which would be selected based on 3 criteria:

   1) Introduction of corporate governance by an organization considered;
   2) Availability of infrastructure and staff;
   3) Introduction of DMP.

e. Strengthening of primary health care and building capacity of health workers, including training of specialists of pilot organizations through the training of trainers by selected strategic partners out of the trained faculty of medical universities. .

f. Improving the system for monitoring and evaluation of performance on primary and secondary prevention of diseases, and effectiveness of health expenditures and health services.

g. Facilitation of the processes of introducing electronic health records as an information tool for the PHC physician for ensuring continuity of health care delivery.

h. Developing a citizen/patient feedback and dialogue mechanism (for example, a PHC scorecard) to enhance responsiveness, accountability, and performance of PHC providers, and building service provider capacity and awareness.

3. Support to implementation of prospective plans of health facility network development based on the recommendations of the master plans. Optimizing capacity of health facilities to ensure accessible secondary and tertiary care; supporting high-resolution outpatient diagnostic and treatment schemes for high-volume, low-cost specialized services; and applying the mechanisms and implementing PPP schemes. While the Health Strategy for 2016-2019 envisages establishment of regional networks of long-term and palliative care organizations by regional authorities as part of the prospective plans' implementation, the Project would support a few pilot projects in this area from

design to the transfer of prepared PPP transactions to regional authorities if the PPP option is used. The subcomponent's main activities would be the following:

a. Determination of the need for development of a health system infrastructure based on strategic development goals, adaptation of international standards for planning, design, construction, and equipping of health care facilities, and for ensuring quality of health care services.

b. Development and improvement of regulatory framework on mechanisms for development of PPP and investment planning in the health sector based on international experience.

c. Improvement of investment planning in the health care sector on the basis of ensuring the just, rational, and effective allocation of health care funds, including through the development of public-private partnerships in the health care sector.

d. Assistance in updating the regional prospective plans of health facility network development, taking into account recommendations of the master plans and priority development of primary health care as well as laboratory services.

e. Support to the process of the decentralization of PHC services in order to ensure wide coverage and high availability, and for the centralization of high-tech and/or highly specialized health care services, including clinical diagnostic laboratories.

f. Support to the increase in the share of outpatient services, including day-hospital technologies and outpatient surgery, in total amount of health care utilized by the population.

g. Facilitation of the processes of restructuring and differentiation of inpatient hospitals and hospital stock according to the degree of intensity of treatment: active, rehabilitation, or long-term care.

4. Strengthening of Emergency Medical Services (EMS). Main activities would be the following:

a. Facilitate the gradual transformation of EMS by improving the dispatcher's network and triage system; reorient "green"[32] emergency cases to the level of primary health care during working hours.

[32] Throughout a triage process, the EMS dispatcher will classify medical emergency calls into "immediate (Red)", "delayed (Yellow)" and "minor (Green)" cases and send the emergency field teams (for red and yellow cases), and reorient green cases to PHC.

b. Provide methodological support to the introduction of international standards of EMS functioning based on the strengthening of practical skills and the introduction of standardized algorithms for emergency medical services.

c. Assist in the revision of standards of EMS staffing, involving expansion of the nursing and junior medical staff.

d. Support the establishment of a national coordination center with regional branches for coordination of emergency medical services, air medical services, and telemedicine.

e. Support the establishment of a call-center on health care issues to ensure feedback, inform patients, and manage patient flows.

(b) Subcomponent 2.2: Managing the quality of health care services. This subcomponent would support the establishment of a comprehensive system of health care services quality management through the standardization of health care, development of Health Technology Assessment (HTA), and introduction of corporate governance/management principles for health organizations. The subcomponent would also support the laying of institutional foundations for the functioning of the Joint Commission for Quality of Health Services (JCQHS) as a platform for developing recommendations on improving of medical education standards, clinical protocols, drug provision, and standards for control over quality and accessibility of health services, with subsequent transformation into a self-regulated organization able to take decisions and to develop, implement, monitor and evaluate regulations in the health care quality, drug supply, and medical education areas. At the same time, introduction of corporate governance/management principles would increase effectiveness of quality management in each health organization owing to the implementation of internal audit units for detection, discussion, and joint elimination of potential shortcomings in both operational activity (clinical audit) and financial and economic activities (financial audit). The subcomponent would focus on further expansion of achievements in development and implementation monitoring of health care standards, clinical protocols (CP), disease management programs, accreditation of health care organizations, conduct of HTAs, improvement of the formulary system under the JCQHS umbrella as well as introduction of corporate governance/management principles in health care organizations for effective introduction of quality management system into practice. During implementation of this subcomponent, significant attention would be paid to the maintenance of professional development and to establishing a culture of high ethical principles among the developers of CP, HTA experts, and reviewers and independent experts; and to the formation of a healthy competitive environment among the providers of health services through involvement of professional medical associations and independent organizations and associations to conduct confidential audits, with subsequent publication of related reports. Patient safety and publication of reports on identified undesirable events would become a fundamental principle in quality management in each health organization, including through the development of internal audit function.

Improvement of quality introduction tools would allow practitioners to provide health care in accordance with international best practice, and would help improve the treatment outcomes

and quality of life of patients, including those with chronic diseases. Introduction of evidence-based clinical protocols and regulation of the system for Health Technology Assessment based on principles of clinical effectiveness and cost-effectiveness would allow for reducing state expenditures on procuring drugs, medical supplies and devices, as well as on treatment of diseases caused by excessive prescription and uncontrolled use of services and drugs. All of this would have a direct impact on the economy by reducing the number of days of temporary disability of the population and ill-health benefits spending, and increasing the number of able-bodied people, in general.

Plan of the key activities:

1. Improvement of clinical practice. Main activities would be the following:

    a. Development of a system for implementation of clinical protocols. Professional associations would be involved in the development and introduction of clinical protocols into clinical practice through the development of introduction tools (algorithms, care pathways for patients, and so forth) at each level of health care delivery by specialty as well as through the monitoring of training and application of tools for introduction of clinical protocols by practicing physicians in each specialty at the regional and republican levels. Evidence-based medicine centers would serve as agents for introducing evidence-based medicine into practical healthcare and education process. Evidence-based medicine centers at higher medical science education institutions, scientific research institutions, and national centers would train practicing physicians in correct use of the tools for introduction of clinical protocols (algorithms, care pathways for patients, and so forth) by specialty. At the same time, ethical aspects during training and scientific evidence databases would be essential for avoiding influence of competition among medical schools and of long-standing practices. Health organizations participating in implementation of clinical protocols, including disease management programs, would be provided with medical supplies and equipped with medical and portable laboratory equipment required in accordance with clinical protocols.

    b. Establishment of a system for monitoring introduction of clinical protocols into daily practice.

2. Further development of HTA. Main activities would be the following:

    a. Consolidation of drug formulary with clinical protocols based on HTA.

    b. Institutional strengthening of HTA.

3. Expanding disease management programs (DMPs). Main activities would be the following:

    a. Further introduction of DMPs in pilot PHC organizations and expansion of the number of health facilities implementing DMPs.

b. Establishment of a system for monitoring and evaluating the effectiveness of the introduction of DMPs.

4. Improvement of quality management mechanisms in health facilities and development of accreditation program. Main activities would be the following:

    a. Introduction of corporate governance / management principles for health organizations.

    b. Development of the health facility accreditation program.

(c) Subcomponent 2.3. Strengthening of human resources for health care based on strategic partnership. The purpose of this component is to develop an effective human resources policy for the sector, which ensures the provision of high-quality health care services, through strategic partnerships. This would be achieved by building the key components of the elements of medical education in accordance with the needs of the health system. Within the framework of this subcomponent, the following are planned: (a) establishment of strategic partnerships with leading academic centers on modernization of medical education; and (b) strengthening of human resources in the health sector. In particular, the subcomponent would support improvement of principles of management and financing of medical education in the transition to the autonomy of education and science organizations; improvement of the education process through introduction of a new policy for admission to medical science education institutions and revision of existing education programs to enable development of physicians' competencies; improvement of the existing system for independent assessment of competencies of medical school graduates and practicing health specialists; and introduction of modern HR technologies for personnel management. All these would contribute to the high-quality training of health care personnel in the country, focused on the needs of the sector.

Plan of the key activities:

1. Improving principles of medical science education,[33] management, and financing to facilitate a gradual transition to the autonomy of medical education, and integration of medical education, science, and practice.

    a. Further introduction of modern forms of management and financing of medical education organizations.

    b. Developing and implementing new mechanisms for the integration of clinical, educational, and research organizations and the industrial sector (the medical and pharmaceutical industry). This would also facilitate the establishment of scientific and educational holdings and regional innovation hubs.

2. Improving the education process in line with international standards to advance the quality of medical science education for health sector workers.

[33] Medical science education refers to education and training of health personnel including, doctors, pharmacists, nurses, and other health workers.

a. Introducing and supporting continuing medical education programs based on competences and professional standards.

b. Improving the quality of education for higher medical science education students based on clinical practice, education, and science.

c. Improving the system of education and training for nurses in accordance with European directives and professional competences.

d. Improving the policy for selection and admission of students to schools of medical sciences based on cognitive skills.

3. Improving the system of independent assessment of knowledge and skills of graduates of higher medical science education institutions and health workers.

a. Improving the methodology of independent assessment of knowledge and skills of health workers and graduates of higher medical science education institutions.

b. Support organizations and bodies (professional associations) engaged in the assessment of knowledge and skills of graduates and health workers (including equipment, training, methodological support /twinning contracts).

4. Supporting the improvement of human resources (HR) management in health facilities.

a. Development of a unified HR register.

b. Supporting the update of HR regulations, including the definition of competences, professional standards, and continuous professional development.

12. Component 2 would finance advisory services and methodological support (including twinning contracts), training, goods, services, and operational costs.

13. **Component 3. Project management, monitoring and evaluation, and communications strategy (US$10.43 million).** This component aims to support a Project Management Unit (PMU) to provide day-to-day project management, including fiduciary and administrative tasks of the Project, as well as monitoring, evaluation, and reporting. The PMU would ensure effective coordination of the Project activities with other programs implemented by the MoHSD, other government agencies, and regional authorities.

14. This component would also support effective information, education, and communication campaigns about the reforms. Implementation of the SHI system and the structural reforms of health service delivery run the risk of being misunderstood by the various stakeholders affected by it. It is essential that all stakeholders, health workers, and the population understand the logic behind the changes and how they will benefit them personally, and their communities. Drawing on lessons from reform initiatives in other countries, this subcomponent would support MoHSD in implementing communications activities to inform the public about the reforms, including about

the new SHI system, their entitlements and responsibilities with reference to the system, and to gather feedback on the reforms. A strong communications strategy is being developed under the KHSTTIRP. Activities for information, education, and communication would include (a) development of a communications strategy focused on both internal (including MoHSD, regional authorities, SHI institutions, and public sector health personnel), and external audiences (including citizens and civil society organizations); and (b) capacity building of MoHSD to implement this communications strategy.

15. Component 3 would also include three levels of citizen engagement activities to be carried out by the Project: (a) Multi-Stakeholder Forums to be held annually to present progress and hear feedback from stakeholders; (b) a community monitoring instrument to track patient perception of the improvements in service provision; and (c) a proactive grievance redress mechanism that would build on and strengthens the already existing mechanisms at the MoHSD level for addressing suggestions and complaints from beneficiaries and various stakeholders. These instruments would be developed in detail prior to effectiveness. Indicators have been included in the Project results framework to report on the improvements in service provider performance, and the credibility and effectiveness of the grievance redress mechanism.

16. Component 3 would finance advisory services, methodological support, communications services, goods, non-consulting services, training, auditing, surveys for Project monitoring and evaluation, equipment, and operating costs of the PMU.

Annex 3: Implementation Arrangements

KAZAKHSTAN

Social Health Insurance Project: Improving Access, Quality, Efficiency, and Financial Protection (P152625)

Project Institutional and Implementation Arrangements

Project administration mechanisms

1. The Ministry of Health and Social Development (MoHSD), as the overarching authority in the health sector, would be responsible for implementation and oversight of the proposed Project. Based on its experience with Bank-funded projects, the MoHSD would develop, steer, coordinate, implement, and monitor Project activities. Other entities involved in Project implementation would include MoHSD-subordinated institutions, the Social Health Insurance Fund (SHIF), the Joint Commission on Quality of Health Services (JCQHS), local executive bodies in 14 oblasts and in Astana and Almaty cities, and the National Health Care Coordination Council.

2. An MoHSD official at the level of Vice-Minister would be entrusted with overall strategic oversight of the Project. Day-to-day supervision and coordination of Project activities within the MoHSD and with the PMU would be the responsibility of the MoHSD's Department of Health Services Standardization (DHSS). This department, through its Director (or, by nomination, his or her deputy) and 1 to 2 designated staff, would also organize meetings of a Core Coordination Team (CCT). Based on positive experience from the KHSTTIRP, salaries of the DHSS Director and the designated staff would be reasonably supplemented by the MoHSD to ensure effective execution of this critical coordination function. The DHSS Director would report to the Vice-Minister in charge, and she or he would, in turn, report on overall implementation status to the Minister of Health and Social Development and initiate the consideration of the most important issues by the National Health Care Coordination Council. The responsibility for ensuring the appropriate fulfillment of fiduciary functions (procurement and financial management) would be entrusted to the Vice-Minister supervising the respective functions within the MoHSD. Final accountability for the Project within the MoHSD would rest with three individuals: the Minister, the Vice-Minister in charge, and the Director of DHSS.

3. The CCT would mirror the same under the KHSTTIRP and be formalized for the proposed Project through a MoHSD order not later than 30 days after the Effective Date. The CCT would provide sectoral policy oversight, stewardship of the Project, and working-level coordination with concerned government agencies and regional authorities. It would consist of heads of MoHSD departments and committees, leadership of the SHIF, and head of the PMU. The MoHSD and SHIF officials represented in the CCT would be jointly and separately responsible for Project components and subcomponents falling into their areas of responsibility, as presented in Annex 5. Representatives of other institutions and government agencies would be invited to join the CCT as needed. The CCT would be chaired by the Vice-Minister in charge and meet as needed but no less than quarterly to review implementation progress and take decisions on issues considered. While not working full time on Project implementation, these officials would remain fully accountable for implementation progress in their respective subcomponents.

4. Given the heavy routine work load of the CCT members, full-time project implementation and management would be carried out by the PMU. Meetings to be chaired by the Vice-Minister in charge would be conducted by the PMU with the Project consultants on a regular basis to review and coordinate implementation of the Project. In addition, the National Project Coordinator would work closely with the DHSS Director and report on a weekly basis to the Vice-Minister in charge on overall implementation progress and issues of importance. All reporting and oversight relationships are summarized in the prepared draft Project Operational Manual (POM) that would be adopted before the Effective Date.

5. The PMU would be enacted within the MoHSD through a MoHSD order before the Effective Date based on the Project Implementation Support Team (PIST) functioning under the KHSTTIRP. The PMU would be accountable to the MoHSD and build on the current PIST's experienced human resources whenever possible and warranted.[34] The PMU would be headed by a National Project Coordinator (NPC) and consist of a team of local technical and fiduciary consultants, and a group of support staff (a total of 24 to 25 individuals).[35] Procurement and financial management functions would be fulfilled by local full-time PMU consultants with experience in World Bank procedures. At the same time, efforts to build such capacity within the MoHSD would be continued under the proposed Project.

6. While the main consultants of the current PIST would be moved to the new Project's PMU, financing of PMU consultants' fees would follow more streamlined arrangements by flowing directly from Project funds without being channeled through a MoHSD-subordinated agency, as was the case under the KHSTTIRP. The CCT members responsible for Project implementation, being core MOH staff, would be financed by the Government of Kazakhstan (GoK) through regular salaries, with an adjustment in their work program to allow sufficient time for Project-related tasks. These arrangements are considered optimal given the high work load of MoHSD staff and the need for additional staff to manage administrative, fiduciary, logistical, and some technical tasks, and to ensure coordination. Such arrangements do not represent a traditional Project Implementation Unit approach, since PMU consultants would *not* have decision-making authority and would be hired solely to facilitate the day-to-day management of Project implementation. In addition, since the Project represents an integral part of the GoK's new State Health Care Development Program for 2016–2019, the responsibilities of MoHSD staff under the Project would be essentially the same as their responsibilities for implementation of the new Health Strategy.

7. The SHIF would be established through a GoK decree. It would be both one of the beneficiaries and implementing entities. As the beneficiary, the SHIF it would receive technical assistance, goods, training, and operational support, while as the implementing entity, it would be involved in the design and implementation of mechanisms, tools, and processes envisaged under

[34] Like the PIST, the PMU would consist of a group of individual consultants hired by and functioning within the MoHSD, with no legal entity establishment required for their functioning. A few core technical and fiduciary staff of the PIST would continue implementation of the KHSTTIRP remaining components until June 30, 2017. Hence, they would also concurrently serve as the core PMU for the proposed Project.

[35] In addition to the NPC, there would be specialists in health insurance, public health, health care quality, medical education and human resources for health, financial management and disbursement, procurement, environmental and social safeguards (as needed). Project assistants, translators, and other administrative personnel would also be engaged on a short-term, as-needed basis.

the Project (although funding for these activities would be managed by the PMU / MoHSD). Institutionally, the SHIF would be a non-profit joint stock company subordinated to the GoK, with the MoHSD represented in the SHIF Board. Operationally, the CEO of the SHIF would be a member of the MoHSD CCT for the Project.

8. The JCQHS was established on November 30, 2015 through the MoHSD Order No. 926 titled "On establishment of the Joint Commission on Quality of Health Services" based on the existing Medico-Economic Council. It has the objectives of improving of medical education standards, clinical protocols, drug provision, and standards for control over quality and accessibility of health services. During the transition period (until 2018), the JCQHS would consist of representatives of non-governmental organizations (NGOs) and serve a consultative function developing recommendations on the specified areas. Upon its readiness to take over part of the MoHSD functions (as of 2019), the JCQHS would function as a self-regulated organization able to take decisions and to develop, implement, monitor and evaluate regulations in the specified areas. It would serve as a platform for interaction of NGOs (associations of employers, health providers, and patients), government agencies, and international organizations. Under the Project, the JCQHS would benefit from organizational and methodological support, advisory services, and extensive capacity building.

9. It is envisaged that various MoHSD-subordinated institutions, including the technical centers established under the KHSTTIRP, would potentially be involved in the technical implementation of Project activities. The Project would not finance recurrent costs of these institutions; rather, the institutions would be engaged in the provision of various specific services corresponding to their technical competence areas. As such, they would be contracted under a sole-source selection arrangement, where warranted, and funded from counterpart funds. Such institutions and their functions are listed in Annex 6.

10. Local executive bodies of 14 oblasts and Astana and Almaty cities, being the owners and managers of all state-owned health care providers in their territory, would support implementation of Project activities at the regional level. These would include, but not be limited to, physical investments in the establishment of regional PHC centers of excellence, small-scale renovation works in existing health facilities, and implementation of disease management programs and communications campaigns at the regional level.

11. Intersectoral policy coordination would be the responsibility of the existing National Health Care Coordination Council, a government-level policy council headed by a member of the Government and comprising representatives of leadership teams of all concerned government agencies and regional authorities. Since the Project touches on a number of key intersectoral issues related to the role of human capital in Kazakhstan's competitiveness agenda, oversight from a high-level body such as the National Health Care Coordination Council would be appropriate. This would take place as frequently as needed in connection with MoHSD's periodic reporting of progress under the State Health Care Development Program. Civil society organizations would help facilitate the implementation of citizen feedback and monitoring mechanisms required under Component 2.

Monitoring and Evaluation

12. *Institutional Arrangements for Monitoring and Evaluation (M&E).* Since the Project represents an integral part of the State Health Care Development Program for 2016–2019, the MoHSD would monitor and evaluate the progress and outcomes of reforms supported by the Project in the context of its overall monitoring of the Program. At the operational level, the responsibility for M&E of the Project would rest with assigned staff at the PMU who would collect, analyze, and report M&E data to the MoHSD and the Bank as part of the PMU quarterly and annual implementation progress reports. The monitoring data would be reviewed by the CCT during its periodic sessions in order to assess the likelihood of achieving the PDOs and to take timely corrective measures as needed. The Project M&E data would also be used in analytical reports on the progress and impact of health sector reforms. To strengthen the long-term capacity of the MoHSD and its subordinate agencies in M&E, selected staff of the MoHSD, subordinate organizations, and PMU would receive necessary in-service and external training under the Project Management component. International advisory services would also be engaged, including for mid-term and final evaluation of the Project.

13. *Data Sources*. To the extent possible, progress on results would be monitored using routine data sources, such as those available from the information systems and administrative records of the MoHSD, its subordinated agencies, the Ministry of Finance, and the National Bank. In addition, monitoring of the outcomes related to financial protection of the population (PDO indicator No. 5) would be done by introducing necessary amendments into the periodic data collection instruments (mainly household health surveys) of the Statistics Committee under the Ministry of National Economy.

14. *Frequency of Reporting.* Data on most Project indicators would be reported on an annual basis. Data on the financial protection of the population (PDO indicator No. 5) would be collected at least three times during the lifetime of the Project (beginning, middle, and end) due to associated data collection costs. Given the dependence of the success of the proposed reforms on beneficiary/stakeholder acceptance, however, (that is, the second attempt at introducing mandatory health insurance, rightsizing hospital capacity, and so forth), progress reports would include data on grievances and resolution on a quarterly basis to allow for timely corrective action. Indicators generated through citizen engagement mechanisms would be reported on annually following the citizen monitoring and feedback process. Evaluation of Project implementation would be done at the mid-term review and Project closing.

Citizen Engagement

15. The engagement of citizens is prioritized in this Project to ensure that the improvements in health care are responsive to the population's needs, and to engage users in the reform of the health care system. Implementation of these activities will be as follows (see table A3.1 for a summary):

(a) The MoHSD will organize a National Multi-Stakeholder Forum for an annual discussion with stakeholders on the change process, and present information on the reform process and future steps, results according to agreed indicators, and budget and financial information, and will facilitate a dialogue with citizens on the reform process.

(b) The PMU will organize the citizen feedback and monitoring mechanism. The mechanism will enhance citizen access to information on health care (national standards/local performance results) and provide a citizen feedback (scorecard) mechanism. This will be introduced in five oblasts by Year 3. This involves not only establishing the process at the local level with the support of a cadre of community mobilizers, but changing staff attitudes through human resource management.

(c) Establishing a proactive Grievance Redress Mechanism (GRM). As noted above, a Project GRM will build on the existing MoHSD system. Implementation arrangements will be established to incorporate proactive feedback approaches that seek the comment and active participation of communities. Options for testing mobile technology feedback will be explored. The credibility of the GRM will be measured annually by an independent survey.

Table A3.1: Citizen Engagement strategy

Citizen Engagement Instrument	**Focus of Operation and Citizen Engagement**	**Purpose/Approach**
Multi-Stakeholder Forum (MSF)	National	Involves all stakeholders in annual discussions and updates on the progress of the reform. Establishes transparency and open access to information on budgets and performance improvements. Effort will be made to ensure the active participation of women, NGOs, and health service providers.
Feedback and monitoring mechanism	Local	Supports improvements to health care services by ensuring patients are aware of national standards, patient rights, and the quality of care provided at the local level. Allows for benchmarking regions/oblasts to incentivize improvements. Important check on progress since it enables comparison between supply-side output information and citizen feedback, as well as feedback from women, men, and youth to build awareness of gender and age benefits. Results will be discussed in MSF.
Grievance Redress Mechanism (GRM)	Sector/project	Channel for citizen complaints. The GRM will take a proactive approach and explore the use of mobile technologies in eliciting feedback. Proactive efforts will be made to ensure women's awareness and use of social accountability mechanisms. Results will be discussed in MSF.

Financial Management, Disbursement, and Procurement

Financial Management

16. The MoHSD, through the existing PIST (to be transformed into the PMU for this Project), will be responsible for implementation of the financial management (FM) function of the Project, including the flow of funds, planning and budgeting, accounting, financial reporting, internal controls, and auditing. The MoHSD, through the PIST, is currently implementing the KHSTTIRP and has overall acceptable financial management arrangements that have been assessed regularly

during FM implementation support missions, with the most recent taking place in May 2015. However, to bring the FM arrangements into fully satisfactory status for the proposed Project, the MoHSD will need to implement some actions. The Action Plan is summarized in table A3.2.

Table A3.2: MoHSD Action Plan

Actions	Responsible Entity	Completion Date
1. Terms of reference for Financial Management Specialist and Disbursement Specialist of the PIST are updated to reflect responsibilities under the proposed Project in a manner acceptable to the Bank	MoHSD	Within one month after signing of the Loan Agreement
2. Develop Financial Management Manual (FMM) as part for the POM	PIST, MoHSD	By Effective Date
3. Develop and launch a module to the existing automated accounting software used by the MoHSD PIST with capacity to generate Interim Unaudited Financial Reports and capture Project's accounts)	MoHSD	45 days after effectiveness

17. *Implementation Arrangements*. The Department of Finance (DF) of the MoHSD, with support from the PMU, will be responsible for preparing annual budgets for the Project based on procurement plans and in line with the Financial Management Manual (FMM) and the budgeting procedures of the GoK. These budgets will form the basis for allocating funds to Project activities. The budgets may be prepared in accordance with the IFR format (disbursement categories, components and activities, account codes, and broken down by quarter). Annual budgets should be agreed with the Bank. Approved annual budgets should then be entered into the accounting system and used for periodic comparison with actual results as part of the interim financial reporting.

18. The PIST/PMU will work closely with the staff of the DF to implement fiduciary functions of the proposed Project. The staffs of both the DF and PIST have experience in World Bank Financial Management and Disbursement procedures gained during implementation of the existing projects and World Bank training in Financial Management and Disbursement procedures.

19. *Accounting.* The MoHSD PIST uses 1C accounting software, which meets both World Bank accounting and reporting requirements and the requirements of the Kazakhstan legislation. However, a module will need to be developed on the basis of this software with a capacity to generate IFRs and capture the proposed Project accounts.

20. The PIST follows the accounting policies and procedures described in the orders and regulations developed by the Ministry of Finance for budget organizations, in addition to the specific financial management procedures, including internal controls described in the POM for the KHSTTIRP. The proposed Project-specific FMM will have to be developed as part of the POM that documents key internal control mechanisms to be followed by staff in the application and use of Project funds, with a specific focus on ensuring completeness of accounting transactions; reliability of accounting data; safeguarding of Project assets, including safe custody of cash and other assets; proper monitoring of contracts; proper authorization and documentation of all Project

expenditures; and full accountability for Project funds. The manual will reflect the Project structure that allows for adequate segregation of functions, job descriptions for staff with different authority levels, and the flow of funds to support Project activities, including proper management of the disbursement function, contracts management, and documentation flow. The manual will also describe procedures for regular financial reporting to ensure close monitoring of Project activities.

21. *Reporting.* Project-management-oriented Interim Unaudited Financial Reports (IFRs) will be prepared under the Project. The MoHSD PIST will produce a full set of IFRs every quarter throughout the life of the Project. The formats of IFRs were agreed during negotiations (and will be incorporated into the FMM). These financial reports will be submitted to the Bank within 45 days of the end of each calendar quarter. The first quarterly IFRs will be submitted after the end of the first full semester following the initial disbursement.

22. *External Audit.* The audit of the Social Health Insurance Project will be conducted by independent private auditors acceptable to the Bank, using International Standards on Auditing (ISA). The auditor will be engaged on standard terms of reference acceptable to the Bank. Audit of the financial statements under the Project will be included in the bulk audit of the whole portfolio of the donor-financed projects in Kazakhstan. Procurement of such is the responsibility of the Ministry of Finance. Cost of the audit is covered by the funds of the Republican Budget outside the Project's costs. Sample audit TORs will be agreed with the Bank and will be attached to the FMM, and the annual audited Project financial statements will be provided to the Bank within six months of the end of each fiscal year, and for the Project also within 6 months after the closing of the Project. If the period from the date of effectiveness of the loan to the end of the borrower's fiscal year is no more than six months, the first audit report may cover financial statements for the period from effectiveness to the end of the second fiscal year. The Borrower will have to disclose the audit reports for the Project within one month of their receipt from the auditors, by posting the reports on the website. Following the Bank's formal receipt of these reports from the Borrower, the Bank will make them publicly available according to World Bank Policy on Access to Information.

23. Table A3.3 identifies the audit reports that will be required to be submitted by the MoHSD together with the due date for submission.

Table A3.3: Required Audit Reports

Audit Report	Due Date
Continuing entity financial statements	Not applicable
Project financial statements The Project financial statements include Sources and Uses of Funds, Uses of Funds by Project Activity, Designated Account Reconciliation Statements, Statements of Expenditure Withdrawal Schedule, and Notes to the financial statements	Within 6 months of the end of each fiscal year, and also within 6 months of Project closing

Disbursements

24. The MoHSD PIST staff have knowledge and experience of the Bank's disbursement procedures. The MoHSD will open a Designated Account (DA) specifically for this Project, in a

financial institution agreed with the World Bank.[36] The Project account will be opened in the Treasury for the transfer of government counterpart funding. Project funds will flow from:

(a) The Bank, either via the DA, which will be replenished on the basis of full documentation or using Statements of Expenditures, or by using the direct payment method or the Special Commitment. Further details on this are provided in the Disbursement Letter; and

(b) Counterpart funds will flow via the Treasury.

25. Both Bank and counterpart funds will be managed by the MoHSD. Withdrawal applications for replenishments of the DA will be sent to the Bank on a regular basis.

Procurement

26. Procurement of Goods and Non-Consulting Services for the proposed Project will be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants," dated January 2011 and revised July 2014 (Procurement Guidelines); and procurement of Consultant services will be carried out in accordance with the World Bank's "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers," dated January 2011 and revised July 2014 (Consultant Guidelines) and the provisions stipulated in the Loan Agreement. The World Bank's "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants," dated October 15, 2006, and revised in January 2011 (Anti-Corruption Guidelines) will apply to this Project. A General Procurement Notice shall be published for the procurements under the Project by the MoHSD.

27. Procurement activities will be carried out by the PMU of the MoHSD. The risk assessment rating for the entire Project will be done through the Procurement Risk Assessment and Management System (P-RAMS). Initial identified risks and proposed mitigation measures are described in table A3.4 at the end of this section. The procurement risk is rated as High.

28. The procurement plan covering the first 18 months of the Project period has been prepared by the existing PIST. The procurement plan will be updated at least once per calendar year, and each update will be subject to the Bank's prior review. The initial procurement plan together with the subsequent updates will be published on the Bank's external website in line with the requirements of the Bank's Guidelines. A General Procurement Notice covering the Project procurement activities has been prepared and published. Specific Procurement Notices will be published for all International Competitive Bidding (ICB) and National Competitive Bidding (NCB) procurement, and for all consulting services contracts as required under the respective Guidelines.

Procurement of Goods. Goods contracts above US$2 million equivalent will be procured under ICB procedures using the Bank's Standard Bidding Documents for procurement of goods. The NCB method will be applicable for procurement of goods contracted with an estimated budget of less than US$2 million. The Europe and Central Asia Sample NCB bidding documents shall be

[36] All DAs may be moved to the Treasury at some stage during project implementation, in which case it will be applicable to this Project as well.

used, taking into account the NCB conditions set forth in the Financing Agreement. Goods contracts with an estimated budget of less than US$100,000 equivalent may be procured using shopping procedures on the basis of at least three written price quotations obtained from qualified suppliers. The list of suppliers to be invited to submit quotations should be defined by an evaluation committee. Direct contracting may be an appropriate method under the specific circumstances. The Borrower shall submit to the Bank for its review and no objection a sufficiently detailed justification, including the rationale for direct contracting instead of a competitive procurement process and the basis for recommending a particular firm in all such cases.

Selection of Consultants. The methods for selection of consultants will include Quality and Cost-Based Selections (QCBS), Quality-Based Selections (QBS), Fixed Budget Selection (FBS), Least-Cost Selection (LCS), Selection Based on Consultants Qualifications (up to US$300,000), Single-Source Selection in compliance with Paragraph 3.8 of the Bank's Consultant Guidelines, and individual consultants (ICs). Contracts estimated to cost above US$300,000 equivalent will be advertised through United Nations Development Business (UNDB), the Bank's website, and local media (one newspaper of national circulation or the official gazette, and MoHSD's website). Shortlists of consultants for services estimated to cost less than US$500,000 equivalent per contract may be composed entirely of national consultants under the provisions of paragraph 2.7 of the Bank's Consultant Guidelines.

Operating Costs. The expenses of the PMU would include communications, translation/interpretation, bank charges, office supplies, cost of advertisements, and mail and business trip expenses of government officials and other experts. Such costs will be financed by the Project based on the annual budget prior reviewed and agreed by the Bank. Purchases will be carried out in accordance with the implementing agency's internal administrative procedures. Operating costs will not include salaries or allowances of civil servants.

Training and Study Tours. Training and study tours will be carried out based on the annual training/study tours program and budget to be prepared by the PMU and reviewed and agreed by the Bank. The institutions for training/study tours will be selected considering the availability of such services, duration of training/study tour, and reasonableness of cost.

Governance and Anti-Corruption Action Plan (GAC). The Project will follow the Bank Group's anticorruption policies as set forth in the Guidelines: On Preventing and Combating Fraud and Corruption in Projects financed by IBRD Loans and IDA Credits and Grants (current edition). The Bank team intends to maintain close oversight and will carry out prior review of all major contracts according to the thresholds that will be regularly reviewed and adjusted as needed in the procurement plan. The following measures will be carried out to mitigate corruption risk:

- *Publication of Advertisements and Contracts:* All publications for advertisements and contract awards, including the results of the awards, will be done in accordance with the Procurement Guidelines and published in the Bank client connection system and on external websites, that is, the UNDB and Bank websites.
- *Debarred Firms:* Appropriate attention will be given to ensuring that debarred firms or individuals (to be verified from the Bank's external website) are not given opportunities to compete for Bank-financed contracts.

- *Temporarily Suspended Firms*: Appropriate attention will be given to ensuring that temporarily suspended firms or individuals (to be verified through client connection) are not given opportunities to compete for Bank-financed contracts.
- *Technical specifications*: The technical specifications will be prepared (or approved) by the project beneficiaries/product end-users.
- *Complaints:* All complaints by bidders will be diligently addressed and monitored in consultation with the Bank.
- *Monitoring of Contract Awards:* All contracts are required to be signed within the validity of the bids or proposals and, in the case of prior review contracts, promptly after the Bank's "no objection" is issued. The procurement plan format shall include information on actual dates (of "no objections" and award) and will be monitored for cases of delay, which will be looked at on a case-by-case basis to identify the reasons. Five largest value contracts will be selected for tracking progress against the critical paths as per procurement plan. The PMU will maintain up-to-date procurement records available to the Bank staff and auditors.
- *Monitoring of Payment Compared to Physical Progress:* Monitoring reports prepared for the Bank will be customized to include a form to monitor physical progress compared to payment installments to avoid front-loaded payments.
- *Timeliness of Payments:* The PMU will maintain a system/database to ensure payments to suppliers and contractors are paid without delay according to the conditions of the contract.
- *Frequency of Procurement Supervision*: Initially, procurement supervision will include prior review of contracts and procurement implementation support missions (part of Project implementation support missions) once every six months. Once the capacity of the implementing agency is strengthened, the frequency of procurement implementation support missions and prior review thresholds may be revised.
- *Post-Review*: 20 percent of all contracts not subject to prior review will be post-reviewed. There will be a number of shopping contracts.

Table A3.4: Summary of Procurement Risk Assessment

Risk	Rating Before	Mitigation	Rating After
MoHSD staff lack capacity to undertake the proposed procurement work under the Project, particularly regarding Bank procurement guidelines.	High	A qualified procurement consultant will provide on-the-job training to MoHSD staff and to bid evaluation committee members. Consultant will provide assistance to the tender/evaluation committee in the preparation of bidding documents, bid evaluation reports, and contract agreements. Training in procurement under Bank guidelines will also be provided by Bank staff during the Project launch workshop.	Substantial
In IT Packages, collusion among the bidders was noticed despite best efforts.	High	The MoHSD will hold a bidders conference with Bank participation and consider the use of two-stage bidding.	High
Bid evaluation committee members are not familiar with international procurement procedures, and may obstruct or delay the procurement process,	Substantial	Consultant will provide assistance to the evaluation committee in the preparation of bid evaluation reports and contract agreements. The risk may continue to be substantial as some of the evaluation committee members may not agree with the consultant assessment. The final	Substantial

especially the evaluation of bids and proposals.		decision will be taken by the evaluation committee.	
Lack of awareness of procurement opportunities available in the Project for goods and services.	Substantial	Carry out public awareness programs using various media, such as newspapers, brochures, radio, TV, Project website, etc.	Moderate
Average Risk	High		Substantial

29. Prior review thresholds will be set up in the Project procurement plan and will be generally based on the following requirements:

- All goods contracts awarded through ICB and NCB (>US$500,000).
- All consulting contracts for firms >US$200,000 and contracts with individual consultants estimated to cost US$100,000 equivalent or more.
- All direct contracts and single-source contracts.

30. The prior review thresholds will be periodically reviewed and revised as needed during Project implementation based on risk assessment, procurement post-review reports, and improved capacity of the implementing agency.

31. Disclosure: The following documents shall be disclosed on the MoHSD website: (a) procurement plan and updates, (b) invitation for bids for goods and works for all ICB and NCB contracts, (c) request for expression of interest for selection/hiring of consulting services, (d) contract awards of goods and works procured following ICB/NCB procedures, (e) list of contracts/purchase orders placed following shopping procedure on a quarterly basis, (f) short-list of consultants, (g) contract awards of all consultancy services, (h) list of contracts following Direct Contracting (DC), Selection Based on the Consultants' Qualifications (CQS) or Single-Source Selection (SSS) on a quarterly basis, (i) monthly physical and financial progress of all contracts, and (j) quarterly reports on actions taken on the complaints received.

32. The following details shall be sent to the Bank for publishing on the Bank's external website and UNDB: (a) invitation for bids for procurement of goods and works using ICB procedures, (b) request for expression of interest for consulting services with an estimated cost greater than US$300,000, (c) contract award details of all procurement of goods and works using ICB procedures, (d) contract award details of all consultancy services with an estimated cost greater than US$300,000, and (e) a list of contracts/purchase orders placed following DC, CQS, or SSS procedures, on a quarterly basis.

Environment, including Safeguards

33. OP 4.01 Environmental Assessment will not be triggered. All project activities including activities under Component 2 will not relate to and will not lead to generation of medical waste, disposal of old medical equipment and radioactive materials. Thus, the requirements of the Framework Environmental Management Plan (FEMP), which was earlier developed by the Counterpart, do not anymore apply to the Project.

Annex 4: Implementation Support Plan

KAZAKHSTAN

Social Health Insurance Project: Improving Access, Quality, Efficiency, and Financial Protection (P152625)

Strategy and Approach to Implementation Support

1. The Implementation Support Plan would comprise of day-to-day supervision by local Bank staff, regular dialogue with the GoK, recurrent joint reviews of Project implementation, and regular supervision of Project implementation and fiduciary activities. Day-to-day supervision by local staff will contribute to supporting Project implementation and identifying situations that might require specific reviews or meetings. Regular dialogue would facilitate early identification of problems, the involvement of key stakeholders, and timely provision of technical advice and support to remove obstacles. Reviews would take place at least twice a year, aimed at reviewing progress and achievement of agreed results. During each of the reviews, the type of implementation support that is needed would be identified, followed by joint decisions on specific necessary assistance.

Implementation Support Plan

Table A4.1. Implementation Support Timeline

Time	Focus	Skills Needed	Resource Estimate
First 12 months	*Regulatory framework and institutional development for implementation of SHI system* *Launch the reform supported by Component 2*	Task Team Leader Health Economist Senior Operations Officer Procurement Specialist Social Specialist Financial Management Specialist Health Insurance Specialist – Short-Term Consultants (STCs) Medical Equipment Specialist – STC Communication Specialist – STC	*100 staff weeks*
12–48 months	*Implementation of SHI system and Component 2* *Monitoring*	Task Team Leader Health Economist Senior Operations Officer Procurement Specialist Social Specialist Financial Management Specialist Health Insurance Specialist – STC Medical Equipment Specialist – STC	*300 staff weeks*
49–60 months	*Completion of all pending activities* *Project evaluation*	Task Team Leader Health Economist Senior Operations Officer Procurement Specialist Social Specialist Financial Management Specialist Health Insurance Specialist – STC	*120 staff weeks*

Table A4.2. Skills Mix Required

Skills Needed	Number of Staff Weeks per FY	Number of Trips per FY	Comments
Task Team Leader	8	3	Trips to be combined with other Project support
Health Economist	25	2	Trips to be combined with other Project support
Senior Operations Officer	6	0	Staff based in the field
Procurement Specialist	4	2	
Social Specialist	6	3	
Financial Management Specialist	4	2	
Health Insurance Specialist – STC	16	4	
Medical Equipment Specialist – STC	6	0	
Communication Specialist – STC	8	0	Staff based in the field

Annex 5: Distribution of Responsibilities for Project Components

Social Health Insurance Project: Improving Access, Quality, Efficiency, and Financial Protection Implementation Arrangements		
Project Components	**Strategy/Oversight/Steering Functions**	**Implementation Functions**
At Project level	Vice-Minister in charge of DHSS; Executive Secretary	Head of CCT: Vice-Minister in charge of DHSS (through CCT members) + **National Project Coordinator (NPC)**
Component 1. Supporting implementation of the national mandatory Social Health Insurance system		
Subcomponent 1.1. Establishing and strengthening the organizational and institutional structure of SHI	DHSS Director, Chairperson of CPHS/CEO of SHIF, DF Director	Member of CCT: representatives of DHSS + CPHS/SHIF + DF + PMU Specialist in Health Insurance
Subcomponent 1.2. Strengthening purchasing and payment arrangements under SHI	DHSS Director, Chairperson of CPHS/CEO of SHIF, DF Director	Member of CCT: representatives of DHSS + CPHS/SHIF + DF + PMU Specialist in Health Insurance
Component 2. Strengthening of health service delivery to support implementation of the National Social Health Insurance System		
Subcomponent 2.1. Developing the health facility network	DHSO Director, DIPDPPP Director, DHSS Director	Member of CCT: representatives of DHSO + DIPDPPP + DHSS + PMU Specialists in Public Health and Health Care Quality
Subcomponent 2.2. Managing the quality of health care services	DHSS Director, Chairperson of CCMPA, DHSO Director	Member of CCT: representatives of DHSS + CCMPA + DHSO + PMU Specialists in Public Health and Health Care Quality
Subcomponent 2.3. Strengthening of human resources for health care based on strategic partnership	DSHR Director	Member of CCT: representative of DSHR + PMU Specialist in Medical Education and Human Resources for Health
Component 3. Project management, monitoring and evaluation, and communications strategy		
Component 3: Project Management	DHSS Director, DF Director	Member of CCT: representatives of DHSS + DF + NPC+ PMU FM Specialist, PMU Disbursement Specialist, PMU Procurement Specialist

Note: CCMPA = Committee for the Control of Medical and Pharmaceutical Activities; CCT = Core Coordination Team; CEO = Chief Executive Officer; CPHS = Committee for Payment of Health Services; DF = Department of Finance; DHSO = Department of Health Service Organization; DHSS = Department of Health Services Standardization; DIPDPPP = Department of Investment Projects and Development of Public Private Partnership; FM = Financial Management; NPC = National Project Coordinator; PMU = Project Management Unit; SHIF = Social Health Insurance Fund.

Annex 6: Institutions Potentially Involved in Project Implementation

KAZAKHSTAN

Social Health Insurance Project:
Improving Access, Quality, Efficiency, and Financial Protection (P152625)

Social Health Insurance Project: Improving Access, Quality, Efficiency, and Financial Protection Implementation Arrangements	
Institution Name	**Institution Competence Area**
Component 1. Supporting implementation of the national mandatory Social Health Insurance system	
Center for Economic Research (unit under the Republican Center for Health Development)	Analysis of health expenditures and methodological support to development of new health sector financing methods
Health Information Center (unit under the Republican Center for e-Health)	Capacity building and coordination of information systems development in the framework of Social Health Insurance implementation
Component 2. Strengthening of health service delivery to support implementation of the national mandatory Social Health Insurance system	
Healthcare Management Center (unit under the Republican Center for Health Development)	Health management training and operational research in the area of implementation of new health facility management technologies
Center for Investment Projects and Development of Public-Private Partnerships (unit under the Republican Center for Health Development)	Support to implementation of master plans for hospitals, PHC facilities, and laboratories at regional level, and development of public-private partnerships in the health sector
Accreditation Center (unit under the Republican Center for Health Development)	Development and update of accreditation rules, standards, and procedures; accreditation of health facilities; training of independent experts and decision makers; methodological support and hands-on assistance in implementing standards in facilities being accredited
Center for Health Care Standardization (unit under the Republican Center for Health Development)	Technical and methodological support to development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs), methodological support to integration of PHC and Public Health (through implementation and monitoring of new CPGs at PHC level, and introduction of international ICPC service classifier)

Unit of Electronic Health Standardization (unit under the Republican Center for Health Development)	Development and adoption of e-Health standards, participation in implementation of best practices in Health Information Management, and introduction of international classifiers and terminologies (ICPC, SNOMED [Systematized Nomenclature of Medicine], etc.)
Republican Center for Assessment of Knowledge and Skills (unit under the Republican Center for Health Development)	Implementation of independent assessment of knowledge and practical skills of medical graduates and health professionals, coordination of continuous professional development
Human Resources Observatory (unit under the Republican Center for Health Development)	Collection, analysis, and dissemination of data and information on human resources for health (HRH), monitoring of human resources, research on key aspects of HRH and their impact on health care activities
Unit of Medical Science Education Development (unit under the Republican Center for Health Development)	Implementation of best practices education technologies in the field of vocational training
Drug Information and Analytical Center (unit under the Republican Center for Health Development)	Improvement of pharmaceutical policy; methodological support in the areas of national drug formulary implementation, rational drug use, and drug pricing
National Center for Expertise of Drugs and Medical Supplies	Participation in harmonization of procedures for registration of drugs and medical devices (supplies and equipment) in accordance with international standards and implementation of nomenclature classification of medical devices
National Center of Healthy Life Styles	Participation in development, implementation, and implementation monitoring of intersectoral strategies in public health on health promotion issues
Scientific Research Institute of Cardiology and Internal Diseases	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of cardiologic medical care provision standards development and implementation
National Scientific Center of Surgery named after A. N. Syzganov	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of surgery medical care provision standards development and implementation
Scientific Center of Obstetrics, Gynecology, and Perinatology	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of obstetric, gynecological, and prenatal medical care provision standards development and implementation

National Scientific Medical Center	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring internal diseases medical care provision standards development and implementation
Scientific Center of Pediatrics and Child Surgery	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of child surgery medical care provision standards development and implementation
Scientific Research Center of Eye Diseases	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of ophthalmological medical care provision standards development and implementation
Scientific Research Institute of Oncology and Radiology	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of oncological medical care provision standards development and implementation
Scientific Center of Urology named after B.U. Dzharbusynov	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of urological medical care provision standards development and implementation
Scientific Research Institute of Traumatology and Orthopedics	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of traumatological and orthopedic medical care provision standards development and implementation
Republican Scientific and Practical Center of Psychiatry, Psychotherapy, and Narcology	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of psychiatric and narcological medical care provision standards development and implementation
National Center of Tuberculosis Problems	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of TB medical care provision standards development and implementation
Scientific and Production Center of Blood Transfusion	Participation in development, revision, quality assessment, implementation, and implementation monitoring of Clinical Practice Guidelines (CPGs); monitoring of transfusiology medical care standards provision development and implementation
Scientific and Practical Center of Sanitary and Epidemiological Expertise and Monitoring	Methodological and technical support to activities on identification and analyses of factors affecting health, and on incidence monitoring.

Scientific Center of Hygiene and Epidemiology	Participation in conducting of surveys on communicable and non-communicable diseases
Kazakh National Medical University named after S.D. Asfendiyarov	Participation as a pilot institution in implementing new tools in medical education (educational programs, accreditation standards, innovation technologies, etc.), and introduction of evidence-based medicine (EBM) and HTA into medical education and clinical practice
Astana Medical University	Participation as a pilot institution in implementing new tools in medical education (educational programs, accreditation standards, innovation technologies, etc.), and introduction of EBM and HTA into medical education and clinical practice
Karaganda State Medical University	Participation as a pilot institution in implementing new tools in medical education (educational programs, accreditation standards, innovation technologies, etc.), and introduction of EBM and HTA into medical education and clinical practice
Semey State Medical University	Participation as a pilot institution in implementing new tools in medical education (educational programs, accreditation standards, innovation technologies, etc.), and introduction of EBM and HTA into medical education and clinical practice
West Kazakhstan State Medical University	Participation as a pilot institution in implementing new tools in medical education (educational programs, accreditation standards, innovation technologies, etc.), and introduction of EBM and HTA into medical education and clinical practice
Kazakh Medical University of Continuous Education	Participation as a pilot institution in implementing new tools in medical education (educational programs, accreditation standards, innovation technologies, etc.), and introduction of EBM and HTA into medical education and clinical practice
Republican College for Training and Re-training of Paramedics	Participation as a pilot institution aimed at improving nursing education, and introduction of EBM and HTA into medical education and clinical practice
Professional medical associations, associations of independent experts, and organizations on protection of patients' rights recommended by the joint Commission on Quality of Health Services	Participation in development and implementation of clinical protocols into clinical practice, and monitoring of training and application of tools for introduction of clinical protocols by practicing physicians by each specialty at the regional and republican levels. Collaboration in implementation of DMPs.

Annex 7: Economic and Financial Analysis

I. Overall macrofiscal conditions and implications for health reforms

1. Kazakhstan has accumulated an appreciable amount of wealth over the last decade thanks to its rich oil resources, which have enabled considerable spending on health. Still, the share of GDP spending on health is small compared to other countries (3.6 percent of GDP). Growth in government health spending has been slower than the growth in GDP in recent years, according to the National Health Account (NHA) 2010–2013 report. With the recent shock in oil prices, real GDP growth has decreased significantly, down from 6 percent in 2013 to 4 percent in 2014 to 2 percent in 2015.[37] Against the backdrop of external shocks, economic growth and inflation have decelerated, financial conditions have tightened, and external imbalances are emerging.

2. Although the GoK has always been committed to investment in health, the challenges created by the recent economic situation call for even stronger interventions in the health sector to make sure that disadvantaged people do not fall through the cracks and scarce resources are used wisely to deliver the best value for money. Therefore, the economic and financial analysis places a strong consideration on the equity and efficiency aspects of the Project.

II. Economic analysis

3. The Project involves complex system interventions that work on both financing and service delivery. The causal chain presented in table A7.1 shows potential benefits from the Project.

Table A7.1: Potential Benefits from the Project

Key Project activities

Design and implementation of a national Social Health Insurance Scheme (SHI)

- Health insurance policy formulation, taking into account the design and operation features, focusing on capacity building and electronic health information system
- Introduction of the schemes of strategic purchasing of health services, focusing on coordination of care
- Limit catastrophic expenditure of the population for the health care by capping out-of-pocket (OOP) expenditures.

Strengthening service delivery to align with the national SHI

- Rationalization and optimization of service delivery network
- Improving quality of care; developing tools, standards, and guidelines; use HTA for basic package
- Strengthening human resources for health (HRH).

[37] Republic of Kazakhstan, 2015 Article IV consultation, IMF Country Report No. 15/241, September 2015.

Expected Project results

- Financing of health services relies less on OOP expenditures at the point of service, which is highly inefficient and inequitable
- Population is protected from catastrophic health expenditure
- The newly established SHIF performs strategic purchasing of services and drugs and improves value for money, informed by a well-functioning data system
- Increased competition among providers spurs efficiency
- The benefits package is explicitly defined, based on HTA, rationalization of drug, and a better drug selection system to assure cost-effectiveness
- Increase of transparency and access of the population to health services thanks to explicit entitlement (through the benefits package) and reduced uncertainty in OOP (especially informal payment)
- Improvement of the health system coordination, with population receiving services of better clinical quality increasing the use of early prevention and promotion and outpatient care
- Integrated approach to PHC improves the effectiveness of disease management, especially NCDs, and reduces the number of NCD complications, hence saving money in the long run
- Organization of service delivery is optimized so as to prioritize PHC, promote integration of care, and reduce the excessive use of unnecessary in-patient services and, potentially, the excessive bed capacity
- Health professionals are well trained and have a profile corresponding to the prevailing disease patterns.

Expected economic benefits of the Project

- Increased efficiency in health spending
- Improved health status due to improved access (granted by health insurance) and quality of care, especially for prevention and management of NCDs
- Reduced financial risks of the population due to catastrophic health spending, reduced precautionary savings for health, and increased investment/spending in other economic activities.

4. The Project was designed to help the GoK achieve the goals of efficiency and equity in the health sector, and for the ultimate outcome of improving the health status of the population. As is clear from the framework above, it is not possible to quantify all economic benefits potentially generated by the Project. The economic analysis, therefore, will rely partly on qualitative information obtained from an extensive literature review. It will also produce some rough estimates of the Project's benefit-cost ratio to guide the decision on the worthiness of the Project's investment. The figures will not be precise, but they are purposely set toward the lower bound by adopting conservative assumptions throughout, as explained further in the sections below.

1. Efficiency consideration

5. In principle, efficiency will be achieved through multiple channels. The biggest promise will come from the optimization of service delivery, in particular, rationalization of hospitals; reducing hospital beds; switching a portion of surgeries to an outpatient care setting; and emphasizing primary health care (PHC), including health prevention and promotion. Efficiency can also be achieved through the strategic purchasing under health insurance by providing incentives linked to performance, adopting centralized procurement of drugs, promoting the use of generic drugs, and using health technology assessments (HTAs) to define the benefits package. Pooling health spending in the society in the form of prepayment/group purchases in principle is more efficient than having individual patients paying for service at the point of delivery through OOP, especially informal payment. Finally, efforts to improve the quality of care over the long run can have a positive impact on efficiency. Although the enforcement of guidelines, treatment

protocols, and other quality standards may impose additional cost in the short run, in the long run, savings can be materialized from better management of disease, especially NCDs, to avoid complications. Not all of these theoretical pathways can be quantified, but the section below reviews the relevant literature to guide our assessment of the efficiency effects of Project activities.

Efficiency gained by reducing hospital use, switching a portion of surgeries to an outpatient care setting, and emphasizing PHC and health promotion

6. The biggest cost saving will likely come from the rationalization of hospitals and the optimization of service delivery. This comes first from the apparent redundancy in hospital capacity in Kazakhstan, a common feature shared by many post-Soviet countries. This will also come from the switch from an inpatient to outpatient setting for many surgical procedures. Day surgery is a rather recent trend that receives considerable attention even in developed health systems such as the United States and the United Kingdom. In 2004, the U.K.'s NHS Modernization Agency published "10 high impact changes for service improvement and delivery," the first of which is "Treat day surgery (rather than inpatient surgery) as the norm for elective surgery."[38] According to this document, this change could not only potentially release half a million inpatient bed days each year in the U.K., it could also improve the experience of the patients and health care providers. Likewise, a recent study in the United States documented that by contracting with some 5,300 ambulatory surgery centers for same-day surgeries, the Medicare program saved US$6 billion during the four-year period 2008–11, and its beneficiaries additionally saved US$1.5 billion in copayments. On average, Medicare payments to these centers equaled only 58 percent of payments to hospitals for the same.[39] This suggests a great potential for cost savings by the Project, which has selected outpatient surgeries as one of its PDOs.

7. The strong emphasis on PHC in this Project is also likely to bring savings over the long run. The role of PHC in early detection, prevention, promotion, and management of NCDs has been well documented. Some of these interventions are highly cost-effective in tackling risk factors for NCDs, such as alcohol abuse, overweight/obesity, lack of physical activity, and tobacco use.[40] A recent *Lancet* publication (cited in footnote) documented that behavioral, environmental, occupational, and metabolic risks can explain half of global mortality and more than one-third of global disability-adjusted life years (DALYs), which underlies the role of prevention in improving health status.[41]

Efficiency gain from improving drug procurement, streamlining clinical processes, and using cost-effectiveness and HTAs to guide the benefit package formulation

[38] "10 High Impact Changes for service improvement and delivery: a guide for NHS leaders," NHS Modernisation Agency, September 2004, Leicester.
[39] "Medicare Cost Savings Tied to Ambulatory Surgery Centers," Ambulatory Surgery Association and University of California Berkeley, 2013;
http://www.advancingsurgicalcare.com/reducinghealthcarecosts/costsavings/medicarecostsavingstiedtoascs.
[40] *Public Health Interventions Cost-effectiveness Database* (PHICED), National Institute for Health and Clinical Excellence (NICE) in the United Kingdom; http://www.crd.york.ac.uk/CMS2Web/.
[41] "Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013," GBD 2013 Risk Factors Collaborators, September 11, 2015; Accessed on Oct 8, 2015 at http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)00128-2.pdf

8. The strengthened use of HTAs will make Kazakhstan follow the good practices in many OECD countries in the use of HTAs to guide decisions on the benefits package. Although cost-effectiveness is not the only criterion for HTA, HTA has a promise of "ensuring value for money."[42] For drugs, in particular, the use of generic drugs and centralized procurement has shown to be a big cost saver elsewhere. For example, depending on the type of drugs, the generic option can save 10 to 90 percent of the cost compared to patented drugs. In the EU health care system, the use of generic drugs is generating some 25 billion euros of savings each year.[43]

2. Access to care, equity, and quality considerations

9. The planned switch from the current national health service system to social health insurance is expected to improve effective coverage. Although, in principle, Kazakhstan already has universal health coverage, access could be limited by the absence of an explicit benefits package that clearly specifies what services are covered. Furthermore, the practice of informal payment is prevalent, and the uncertainty associated with informal payment (patients do not know in advance the exact amount) could be a deterring factor in the decision to seek care by economically disadvantaged people.

10. The literature from similar and more advanced health systems provides positive evidence on the impact of guaranteed free care or health insurance on health outcomes. A classic example comes from an early health insurance experiment in the United States conducted by the RAND Corporation.[44] The study documented that free insurance (with no copayment) led to improvement in hypertension, dental health, vision, and some other serious conditions. The improvements were concentrated among the sickest and poorest patients. In Costa Rica, the switch from a national health service model to health insurance was responsible for a reduction, albeit small, in infant and child mortality.[45] In Argentina, a recent impact evaluation of a program providing free health insurance for low-income mothers and performance-based incentives to providers documented a significant reduction in the probability of low birth weight and in-hospital neonatal mortality rate, by 19 percent and 74 percent, respectively. The intervention is deemed cost-effective, since it was estimated to save a DALY for less than the level of GDP per capita in the same year.[46]

11. Naturally, the main pathway from insurance to health status is increased use of preventive and curative services. The "access value" of insurance has been well documented, whereby insurance removes the uncertainty in the cost associated with OOP (a significant part of it could be informal payment, as mentioned above), and encourages seeking care immediately when needed. In the United States, access to coverage was found to be associated with an array of

[42] C. Sorenson, M. Drummond, and P. Kanavos, "Ensuring value for money in health care. The role of health technology assessment in the European Union," European Observatory on Health Systems and Policies, 2008, Copenhagen.
[43] "The Use of Generic Medicines in Europe," European Generic Medicines Association, 2011; http://www.egagenerics.com/gen-geneurope.htm.
[44] "The Health Insurance Experiment," A Classic RAND Study Speaks to the Current Health Care Reform Debate, *Research Highlights*, 2006, RAND Corporation, Santa Monica.
[45] W. Dow, and K. Schemeer, "Health insurance and child mortality in Costa Rica," *Social Science and Medicine* 2003, 57 (6) (September): 975–86.
[46] P. Gertler, P. Giovagnoli, and S. Martinez, "Rewarding Provider Performance to Enable a Healthy Start to Life. Evidence from Argentina's Plan Nacer," Policy Research Working Paper 6884, World Bank, Washington, DC, 2014.

beneficial effects, such as having a regular doctor, receiving timely preventive care services, and better management of chronic health conditions.[47] Another pathway from insurance to health outcomes could come from the financial protection effect, whereby households are less likely to hold back on spending on food and other necessities in order to save for future catastrophic health payment. This has been found to be the case in the Philippines, where having insurance has shown to improve child nutrition status thanks to the increased spending on food by the insured.[48]

Quantifying the costs and benefits of the Project

12. This subsection compares the economic costs and benefits of the Project to document whether it is a worthwhile investment for the Bank and the GoK. As mentioned above, due to the complexity of the Project design and lack of data, the analysis relies on a number of assumptions. Nevertheless, the cost-benefit analysis leans toward the conservative side to make sure we are not making misguided decisions due to overestimating the Project benefits.

13. The cost-benefit analysis adopts the following definitions, parameters, and assumptions:

Costs of the Project: The costs of the Project are considered investment costs and inclusive of both International Bank for Reconstruction and Development (IBRD) funding and counterpart funding. The total cost is US$90.0 million, of which US$80.0 million from IBRD is assumed to be disbursed from FY17 through FY21, based on the stated schedule of disbursement. The funding from the GoK, US$10.0 million, is assumed to be disbursed equally across the 5 years of the Project.[49] Using the standard discount rate of 3 percent, the net present value (NPV) of the Project investment according to such payment schedules is roughly US$83.5 million.

Benefits of the Project: The benefits of the Project will be quantified in monetary value for two expected outcomes: (1) improved efficiency, specifically the money saved from switching some of the surgical procedures from an inpatient to outpatient setting; and (2) improved health status, in particular the value of gains in health status among the population. The estimation for each is described in more detail below.

Cost saved due to switching a certain number of surgeries to an outpatient setting

14. The base data for this are from 2014, the latest year National Health Account (NHA) data are available. They include:

- The total number of all surgeries in 2014: 672,892 (*Health Statistic Yearbook*)

[47] J. Berstein, D. Chollet, and S. Peterson, "How does insurance coverage improve health outcomes?," Issue Brief, Mathematica Policy Research, Princeton, 2010.

[48] S. Quimbo, J. Peabody, R. Shimkhada, J. Florentino, and O. Solon, "Evidence of a causal link between health outcomes, insurance coverage, and a policy to expand access: experimental data from children in the Philippines," *Health Economics* 2011, 20 (5) (May): 620–30.

[49] It is unlikely that government funding will be disbursed equally across the years. The more likely scenario will be that spending will be low in the first one or two years and pick up in the subsequent years. Assuming equal distribution will make the estimation conservative – due to future discounting, the far into the future the money is spent, the less NPV it is accrued.

- Average cost per surgery: US$1,508 (NHA 2014).

We assume that:

- 25 percent of the total cost of surgeries is being spent on procedures that could be performed as outpatient surgeries.
- For the same surgery, the cost of performing it in an outpatient setting is equal to 60 percent of the cost of performing it in an inpatient setting. This is based on the findings from the U.S. study reviewed above, which revealed that Medicare spent on average 58 percent for the same surgery if conducted in a day surgery center.
- The percentage of surgeries included in the "outpatient elective surgeries" list that are actually performed on an outpatient basis will increase gradually from 2017 through 2021 in accordance with the Result Framework (5 percent in 2017 [same as baseline 2015: 5 percent]; 10 percent in 2018; 25 percent in 2019; 35 percent in 2020; and 50 percent in 2021).
- No further gain is achieved after 2021.

15. The estimated incremental savings in each year of the Project are presented in Table A7.2, which also shows a total savings of around US$40.8 million in NPV.

Table A7.2: Incremental and total savings up to 2021 by performing a portion of "outpatient elective surgeries" in an outpatient setting

Year	% of "Outpatient Elective Surgeries" Performed as Outpatient	Incremental Savings Compared to Preceding Year (US$)
2015	5	0 (2015 is the baseline year)
2017	5	0
2018	10	5,074,577
2019	25	15,223,732
2020	35	10,149,155
2021	50	15,223,732
Total NPV (US$)		40,864,665

Monetary value of gain in health status

16. Gain in health status is measured by DALYs, a unified measure combining years of life lost due to premature mortality and years lived with disability. DALYs is commonly used in the cost-effectiveness analysis of health interventions due to the ability to combine the effects on all health conditions into a single unit. The base data for this estimate are from 2013, the latest year for which DALY data for Kazakhstan are available.[50]

Specific values and assumptions are:

[50] http://ghdx.healthdata.org/record/global-burden-disease-study-2013-gbd-2013-disability-adjusted-life-years-1990-2013.

- The time duration under consideration is the duration of the Project (5 years, 2017–2021). We also consider a 10-year duration, given that the benefits generated by the Project will remain after the Project ends.
- In 2013, DALYs from all causes in Kazakhstan were estimated at 6,106.6 per 100,000 people for a total of 1,042,276 DALYs in 2013.
- The Project will have no impact on DALYs in the first year (2017), but will gradually contribute to DALYs gained over the course of implementation and beyond. Specially, the Project will gain 0.15 percent of all DALYs in 2018 and in 2019, 0.2 percent in 2020, 0.3 percent in 2021, and will continue at that same level beyond 2021.
- The population is assumed to grow by 1.48 percent per year, the level of 2014, according to the *World Development Indicators*.
- Real GDP growth is based on the IMF's projection for up to 2020 (Article IV report), and is assumed to take the level of 2020 for subsequent years.
- A standard discount value of 3 percent is used.
- The monetary value of a DALY gained in a year is set to equal GDP per capita in the same year. This is based on the thresholds for a health intervention to be considered cost-effective (gaining one DALY at a cost of 3 times the level of GDP per capita) or highly cost-effective (gaining one DALY at a cost of 1 times the level of GDP per capita). By choosing the latter threshold, our estimate is on the conservative side.

17. With this set of conservative assumptions, the NPV of DALYs gained attributable to the Project is estimated at US$110.9 million for the 5-year period 2017–2021 and US$335.7 million for the 10-year period 2017–2026.

18. Table A7.3 presents the NPV of the investment compared to benefits gained by the Project. Comparing the two yields, the benefit-cost ratio ranges from 1.8 to 4.5, depending on the time period under consideration. Thus, even under a series of conservative assumptions, and with a high likelihood of underestimating the Project's benefits, the investment yields a positive return.

Table A7.3: Estimated Benefit-Cost Ratio of the Project

	Project Duration 2017–2021	**10-Year Duration - 2017–2026**
NPV of investment	US$83,502,676	US$83,502,676
NPV of benefits	U$ 151,783,872	US$376,600,021
Benefit-cost ratio	1.8	4.5

III. Financial analysis

19. This section considers the sustainability of the Project financing to assess the financial implications for the GoK after the Project ends. It also assesses the implications of the Social Health Insurance (SHI) rollout for the population and for the GoK budget envelope. Although the decision to roll out SHI is the GoK's decision, supporting SHI is a major component of the Project, and, therefore, it is important to consider its potential effects.

1. Sustainability of Project financing

20. Unlike a number of investment financing projects, this Project invests primarily in soft system building, that is, it supports the design and setup cost: policies, legislation, guidelines, and protocols. These instruments, once in place, well tested and fine-tuned, can run by themselves after the Project ends. Therefore, continuation of Project activities even after it ends will not impose a meaningful financial burden on the GoK. To the contrary, since the technical guidelines have been developed and the health personnel trained, the Project's impact will continue for a long time.

2. Fiscal implications of SHI rollout for the population

21. The adoption of SHI reflects the GoK's expectations on individual responsibility for health. However, the rollout of the contributions is set to be staggered to minimize the financial burden on households and employers. The GoK will also use state funding to provide free insurance for a large group, including children, mothers with more than five children, veterans, the disabled, the unemployed, students, non-working pregnant women, parents on parental leave, pensioners and prisoners.

22. According to the Law on Mandatory Social Health Insurance, the SHI Fund will be established in 2016, and collection of contributions will start in 2017. Employees, employers, and self-employed will not pay the full contributions until 2020 (table A7.4). The SHI deductions and contributions will be deducted from personal income tax for formal sector employees and self-employed, and the corporate income tax for employers. Taking into account tax deductions, the actual additional burden on employers when the contribution is collected in full (5% starting in 2020) is estimated at 4 percent.

Table A7.4: Schedule of Contribution Rate Collection, 2017–2024 (Draft Insurance Law)

	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)
State funding (vulnerable population – exemption group), % of average monthly wages of two years ago	4	5	5	5	5	5	6	**7**
Formal sector employees, % of income	0	0	1	**2**	2	2	2	2
Self-employed, informal sector, % of income	2	3	5	**7**	7	7	7	7
Employers, % of employee payroll	2	3	4	**5**	5	5	5	5

23. The exemption group, by the move toward the SHI, will be financed by the GoK and receive medical care equally with the population paying contributions. For formal sector employees, the final contribution of 2 percent is rather small, especially if it will be deducted from the current personal income tax obligations. The employer and self-employed contribution will be a cost that will affect profit margins, and could be a cause for a payroll revision.

24. The SHI rollout will be positive-sum game for the contributing parties if SHI can eventually reduce OOP, which is currently fairly high in Kazakhstan (31.2 percent of total health expenditure in 2013, according to the NHA). In other words, if SHI is successful in reducing OOP ex post, at the point of service, the prepayment of contributions will not impose an additional

financial burden on households. In fact, as we argued above, the switch to SHI should improve efficiency in private spending precisely by converting OOP to prepayment.

25. We performed a rough calculation comparing OOP as it would be based on the current rate (31.2 percent) with the projected contributions by the employees and self-employed. According to our simulation, the SHI contributions by these two groups in 2020, the first year the contributions will be collected in full, is KZT 231 billion. The 2013 value of OOP is nearly KZT 400 billion, an amount equivalent to KZT 563 billion after taking into account inflation (using the IMF's GDP deflator estimates – Article IV report). Thus, without even taking into account the absolute increase in total health spending, the amount saved from reducing OOP can offset the amount of the contributions to the SHI by the employees and self-employed. Of course, OOP will never be fully eliminated; our rough calculation simply shows a large potential for SHI to raise revenue while not imposing an additional financial burden on households.

3. Simulations on a Transition to a New Social Health Insurance System

26. The introduction of the SHI system in Kazakhstan will have no fiscal cost to the GoK, while cost contributions of the private sector to total health care spending may be lowered. Our simulations suggest that the GoK's revenue from labor taxes will remain stable at about 3.1 percent of GDP a year, where contributions to the SHI Fund (to be rolled out from 2017 onward) will be offset by respective tax deductions from social tax and personal income tax (PIT) payments to the budget (table A7.5). The Law on the Mandatory Social Health Insurance envisages a gradual phase-in of contributions from the GoK, employers, and individual entrepreneurs to the SHI Fund starting in 2017, while contributions from individuals will start in 2019 onward. By 2024, all contributions to the SHI Fund should be fully operationalized, bringing annual revenue to the SHI Fund of 1.1 percent of GDP. Since these off-budget contributions will be subject to deductions from regular labor taxes (that is, the social tax and the PIT), on-budget revenue of the national budget will be losing 0.9 percent of GDP every year (i.e. total SHI contributions, excluding GoK's contributions for the vulnerable). The composition of total health care spending is also expected to change as a result of the introduction of the Social Health Insurance System in 2017. Our estimates suggest that while on-budget government spending on health may be lowered by about 1 percent of GDP by 2020 (in favor of spending by the SHIF), costs to the private sector, including household out-of-pocket expenses, may become lower after the rollout of the Social Health Insurance System. If aggregate public spending on health (on-budget and off-budget, through the SHI Fund) will be providing more health services to the population, direct payments by the private sector may be lowered from 1.3 percent of GDP in 2015–16 (this estimate is based on the National Health Accounts for 2010–13) to about 1 percent of GDP from 2018 onward.

Table A7.5. Simulations on Transition to a New Social Health Insurance System

	2015	2016	2017	2018	2019	2020	2025
(In percent of GDP, unless otherwise indicated)							
Labor taxes revenue, total	**3.1**	**3.1**	**3.1**	**3.1**	**3.1**	**3.1**	**3.1**
Budget revenue (social tax and PIT)	2.5	2.5	2.3	2.2	1.9	1.6	1.6
Social security contributions	0.6	0.6	0.6	0.6	0.6	0.6	0.6
SHI contributions			0.4	0.5	0.8	1.1	1.1
Government contribution for vulnerable			0.1	0.2	0.2	0.2	0.2
Employers (deducted from social tax)			0.2	0.3	0.5	0.6	0.6

	2015	2016	2017	2018	2019	2020	2025
Employees (deducted from PIT)					0.2	0.3	0.3
Individual entrepreneurs			0.0	0.0	0.0	0.0	0.0
Health care spending, total	**3.6**	**3.4**	**3.5**	**3.5**	**3.5**	**3.5**	**3.5**
General government spending	2.3	2.1	2.0	2.0	1.7	1.4	1.4
Central government	1.7	1.6	1.5	1.4	1.1	0.8	0.8
Current expenditures	1.4	1.3	1.3	1.3	1.0	0.7	0.7
of which: UNHS expenses	1.2	1.2	1.2	1.2	0.9	0.6	0.6
Capital expenditures	0.4	0.2	0.2	0.2	0.2	0.2	0.2
Regional governments	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Private sector spending	1.3	1.3	1.1	1.0	1.0	1.0	1.0
SHIF budget			0.3	0.5	0.8	1.1	1.1
Memorandum items:							
Tax rates							
Social security contributions	5%	5%	5%	5%	5%	5%	5%
SHI contributions							
Government (% of average wage t-2)			4%	5%	6%	7%	7%
Employers (% of actual wage bill)			2%	3%	4%	5%	5%
Employees (% of actual wage)					1%	2%	2%
Individual entrepreneurs (% of minimum wage)			2%	3%	5%	7%	7%

Source: World Bank staff estimates and calculations.
Note: PIT = personal income tax; SHI=Social Health Insurance; SHIF=Social Health Insurance Fund; UNHS = Unified National Healthcare System.

MAP


RUSSIAN FEDERATION
NORTH KAZAKHSTAN
Petropavlovsk
Kostanai
Kokshetau
Pavlodar
Ekibastuz
AKMOLA
PAVLODAR
Torghay Plateau
KOSTANAI
ASTANA
Esil (Ishim)
Ural'sk
Chapaevo
Aktobe
WEST KAZAKHSTAN
ATYRAU
AKTOBE
Atyrau
Embi
Shalkar
Turgay
Arkalyk
Karaganda
Kazakh Uplands
KARAGHANDY
Zhezkazgan
Balkhash
Saryshaghan
Aral
Baikonur
Kyzyl-Orda
Aral Sea
Caspian Sea
MANGYSTAU
Aktau
Beinau
Ustyurt Plateau
KYZYLORDA
ZHAMBYL
Taldykorgan
ALMATY
Almaty
Shu
Turkistan
Taraz
Shymkent
SOUTH KAZAKHSTAN
Semipalatinsk
Oskemen (Ust-Kamenogorsk)
EAST KAZAKHSTAN
Lake Zaisan
Ayakos
Lake Balkash
Lake Alakol
CHINA
Pik Khan-Tengri (6995 m)
2001 LEVEL OF ARAL SEA
1990 LEVEL OF ARAL SEA
1960 LEVEL OF ARAL SEA
AZERBAIJAN
UZBEKISTAN
KYRGYZ REP.
TURKMENISTAN
TAJIKISTAN
AFGHANISTAN
KAZAKHSTAN
0 100 200 300 Kilometers
0 100 200 Miles
KAZAKHSTAN
SELECTED CITIES AND TOWNS
OBLAST CAPITALS
GALASY (CITIES WITH REGIONAL STATUS)
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
OBLAST BOUNDARIES
INTERNATIONAL BOUNDARIES
IBRD 33425R1
JANUARY 2007