

Use of business planning methods to monitor global health budgets in Turkmenistan

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After undergoing many changes, the financing of health care in countries of the former Soviet Union is now showing signs of maturing. Soon after the political transition in these countries, the development of insurance systems and fee-for-service payment systems dominated the discussions on health reform. At present there is increasing emphasis on case mix adjusted payments in larger hospitals and on global budgets in smaller district hospitals. The problem is that such systems are often mistrusted for not providing sufficient financial control. At the same time, unless further planned restructuring is introduced, payment systems cannot on their own induce the fundamental change required in the health care system.

As described in this article, in Tejen *etrap* (district), Turkmenistan, prospective business plans, which link planned objectives and activities with financial allocations, provide a framework for setting and monitoring budget expenditure. Plans can be linked to the overall objectives of the restructuring system and can be used to ensure sound financial management. The process of business planning, which calls for a major change in the way health facilities examine their activities, can be used as a vehicle to increase awareness of management issues. It also provides a way of satisfying the requirement for a rigorous, bottom-up planning of financial resources.

Keywords: budgets, organization and administration; financing, health; financial management; health transition; Turkmenistan.

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Introduction

The financing of health care in countries of the former Soviet Union has undergone many changes and is now showing signs of maturing. Soon after the political transition in these countries, the development of insurance systems and fee-for-service payment systems dominated the discussions on health reform (1, 2). Often it appeared as if anything was preferable to whatever had been the existing system. As a result, many countries were faced with demands to provide more treatment than was really necessary, funded by new insurance systems that were not properly accountable, and appeared to produce more costs (e.g. in extra administration) than benefits (e.g. from improved efficiency). The process of cost escalation in the Czech Republic (3) and the less well-known instances in other countries, such as Estonia (4), serve as a warning that new payment systems can impose significant costs on impoverished systems.

Changing the payment method to a system of case-based remuneration or global budgets has the potential to moderate these escalating costs and provide the basis for a modern payment system. On their own, however, these methods are unable to

bring about the fundamental restructuring required of the health care system (5). Business plans, agreed between purchaser and provider, offer a way of developing a process of global budgeting or case-based payment which is transparent and accountable. These plans can be used as a basis for fundamental restructuring in a way that even quite sophisticated payment systems alone cannot.

This article describes the process of creating a business plan to establish and monitor a global budget in a rural area of Turkmenistan. The general process of economic and health care transition in Turkmenistan are described first, while subsequent sections describe the business planning process. Although the final product is not revolutionary, the process involved reveals a considerable amount of information about the way in which the health services function and the implied objectives of the providers. Subsequent plans must build upon this process in order to develop a workable system of population-led service planning.

Health care and economic transition

Turkmenistan, the most southerly of the Central Asian republics of the former Soviet Union, has a population of about 4.6 million, most of whom live in the south around the capital of Ashkhabat. The country has borders with Iran, Afghanistan, Kazakhstan and Uzbekistan, and is largely desert in the central part.

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The health status of the population in Turkmenistan compares unfavourably with other countries in the WHO European Region (EUR) (Table 1). The infant mortality rate is three times the EUR average and exceeds the rate in all the other countries in Central Asia. Maternal mortality is similar to that in other countries of the former Soviet Union, but is far higher than the European average. Although the accuracy of these data and their comparability with those from Western Europe have been questioned (6), the picture of (at best) a stagnating health situation or (at worst) serious decline over the last ten years is broadly accepted. Female life expectancy fell from around 70 years in 1989 to 66 years in 1995, while that for males fell from around 63 years to 61 years over a similar period (7). The indicators are usually significantly worse in the rural areas. In the capital Ashkhabat, for example, life expectancy at birth is eight years higher than for the country as a whole.

The country exhibits many of the health system characteristics of other countries of the former Soviet Union (8, 9).

- There is an over-dependence on hospitalization with long periods of stay and a disproportionate number of beds per capita.
- The health service is multi-layered, with national level tertiary facilities, regional level specialist and general hospitals, district level hospitals, urban polyclinics, and small rural hospitals and ambulatory clinics.
- The urban polyclinics have a combination of specialist and general doctors, while rural clinics are run by a triumvirate of doctors: a paediatrician, a therapist for adults, and a gynaecologist.
- In the more remote rural areas, the small clinics are run by feldshers, a type of nurse/paramedic who provides first-contact medical treatment.
- Specialization and hospitalization are encouraged, on the one hand, by professional status and cultural acceptability, and on the other by a financing system that favours large hospitals and fully occupied beds.

As in other countries of the former Soviet Union, Turkmenistan has suffered a deep economic recession. Between 1991 and 1995 the economy declined by

more than 23%, while government revenue fell by around 80% (10). This decline has continued in recent years. Economic decline was a product of the general restructuring of state industries and collapse of guaranteed Eastern Block export markets. The country's revenue comes primarily from the export of gas and cotton. Although gas reserves are substantial and predictions of future economic growth are good, most existing pipelines are to other countries of the former Soviet Union that cannot afford to pay for supplies. New pipelines are being built, but the political instability in many of the bordering countries makes export of gas a risky business.

Declining revenues have meant that expenditure in the public sectors including health has declined. Annual per capita spending on health declined from around US\$ 125 to about US\$ 40 between 1990 and 1996, although parallel changes in exchange rates and high inflation hinder accurate conversion (11). Official finance for the health sector still comes predominantly from the state budget, although a voluntary insurance scheme introduced in 1996 provides between 3% and 5% of the revenue. External loans and grants provide more than 20% of the health sector budget. Most of the state health budget is spent on national and regional level facilities (43%) and district hospitals (46%). A relatively small proportion goes to rural ambulatory and small inpatient facilities (11%). In addition, as in other parts of the former Soviet Union, there is growing evidence of use of substantial unofficial charges for care to supplement the inadequate budget. Ladbury, for example, reported that patients collectively contribute more than 13% to the actual health care spending through a range of substantial non-monetary gifts to medical practitioners (12). As this was a rural study and payments tend to be higher in the richer urban areas, it is likely that the total figure is much higher. Anecdotal evidence indicates that doctors may refuse treatment if the value of the actual or proposed gift is not large enough.

In 1997 the Turkmenistan government, assisted by WHO, UNDP and the World Bank, began to implement a plan of restructuring that placed emphasis on primary care and prevention of common diseases (13). The changes include devel-

Table 1. Health status in Turkmenistan and regional comparator countries, 1994^a

	Turkmenistan	Kazakhstan	Russian Federation	Turkey	All Europe
Infant mortality rate (per 1000)	42.9	27.4	18.6	47	14.2
Maternal mortality rate (per 1000)	42.6	48.2	52.3	180	21.9
Life expectancy at birth (years)	64	65.6	64	66	72.3
GDP per capita (\$PPP) ^b	3469	3284	4464	5230	18 720
Inpatient admission rate (%)	16.6	17.9	20.9	5.9	16.9 (11.4) ^c
Beds (per 10 000 population)	95.2	113.7	124	24	71.4 (21.7)

^a Source: WHO, Health For All (Europe) database.

^b PPP = purchasing power parity.

^c Figures in parentheses are for the United Kingdom.

opment of a general practitioner system of primary care, closure of many small hospitals, and a greater emphasis on outpatient forms of treatment.

Allocating health care resources in Turkmenistan

Previously the system for financing the health sector in Turkmenistan was similar to that in other countries of the former Soviet Union. Most funding was obtained from taxes and transfers from state enterprises. Consolidated local and national budgets were approved by the local finance departments and the National Ministry of Finance based on norms that were related to current staff numbers and past activities. In the health sector, staffing was related to the number of beds for inpatient care, and the size of the population for outpatient care. Since funding was related to "inputs" rather than outputs or outcomes, there was a clear incentive not to reduce the size of institutions or the number of bed-days. The normative approach was combined with a tight control of line items — for example, budgets worked out on a normative basis for staffing, food or drugs could not be spent on other things.

Many countries of the former Soviet Union are currently introducing new systems of funding health care providers that are based on outputs rather than inputs. Early attempts at reform in Eastern Europe and countries of the former Soviet Union introduced systems of fee for item of service payment (13). These were quickly seen to be an incentive to overtreat patients. Recent changes have concentrated more on *case mix adjusted payment* (where facilities are paid according to the number of patients treated, adjusted for the complexity of the case) and *global facility budgets* (where facilities are allocated a fixed budget which is not reduced if staffing or other inputs are reduced). Such systems reduce the incentive to overtreat although an incentive to overadmit patients still remains.

In Turkmenistan, case mix adjusted systems may be appropriate for tertiary level regional hospitals sited in urban areas where the competitive pressures of a case-based system could be used to induce change. At the *etrap* (district) level the situation is rather different. Health services are currently based on a local, vertically integrated monopoly where the head of the *etrap* health services also runs the main hospital, small rural hospitals and outpatient centres. Most district hospitals in rural Turkmenistan do not use computers to help adjust their budgets. All statistics are laboriously copied out by hand and then sent to the *etrap* and regional health administrations. Currently, case mix systems therefore do not seem appropriate since there is no competition and hence the capacity of a payment system to bring about change in infrastructure is severely limited. Instead, a simple global budget for the entire budget together with plans for bringing about restructuring appears to be a more promising route to bringing about fundamental change.

The health system in Turkmenistan is in need of fundamental transformation in order to place greater emphasis on primary care and outpatient alternatives to inpatient care. This will require retraining of staff, restructuring of facilities, and selective investments in more effective and cost-effective technologies. The inherent incentive to increase productivity works well where available resources are known in advance and are reasonably abundant. However, where there is a threat that money paid for each patient will suddenly and drastically be cut, the system is likely to work less well. Similarly, since much of the emphasis will be on redirecting patients to the outpatient level, incentives to increase inpatient admissions may impede the change process. While it would be possible to establish incentives that work to increase the use of outpatient care, the resulting payment system is likely to be unnecessarily complex for a relatively small and managerially unsophisticated hospital. Instead, an approach that combines regulated restructuring with simple, positive incentives for efficiency is preferable.

A planned approach to budgeting can be provided through a global provider budget. Initially global budgets can be based on historic expenditure but adjusted later to encourage particular system changes. Budgets are relatively straightforward to establish and minimize financial uncertainty over allocations for both providers and funders (purchasers). In many OECD countries, global hospital budgets have been used to control health care spending (14). Two problems are apparent with this approach. First, finance departments may be loath to give up the line item approach to financial control, which, though rigid, did provide a detailed check on expenditure, while for an open budget the spending is left to the discretion of the hospital management. A frequent complaint is how to prevent the chief doctor using all the budget for staff bonuses. Second, in the absence of other checks there are no incentives to maintain levels of activity or standards of quality.

The first of these problems probably arises from a misconception of what constitutes good budgeting practice in countries applying a global budget or capitation principles of finance. Dismantling tight line control from above does not necessarily imply an absence of control. Most budget holders in western countries are in the position where they must account for expenditure against an agreed budget and then explain large deviations from it. This differs from the line-based approach in that the budget is constructed by the budget holder based on planned activities, rather than norms, and then approved by the administrative level.

The second of these problems relates to the issue of monitoring quality and activities. It is important to realize that although a minimal number of indicators are used to set and pay the budget, a much more complex data set could be used to measure the overall performance of the provider. Ultimately the evaluation of performance can be used to modify the budget in the current or future years. In

Western European countries, such as the United Kingdom, the contracting process can be complicated, only a small part of which actually states the terms and conditions for payment. The rest of the process describes key indicators that will be monitored, including targets or goals set by the health care provider (see, e.g. 15). Failure to meet these targets can be met by a combination of “sticks”, in the form of reductions in budget or non-payment of bonuses, and “carrots” such as the provision of management support to increase the likelihood of achieving targets in the future.

Changing provider incentives in Turkmenistan

In Turkmenistan, a World Bank health project has been carried out in Tejen *etrap* situated 120 km from Ashkhabat. Compared with the health status indicators in rest of the country, those in this *etrap* are average or worse: the infant mortality rate is 40.8 per 1000 population, while the 5-year average maternal mortality rate is more than 190 per 100 000 (although the absolute numbers are small and exhibit wide annual variation).

The objective of the World Bank project is to enhance mother and child health status through general investments in primary care and targeted investments in emergency obstetric inpatient care. General practitioners will be trained to provide primary care. Part of the project will test out a reformed provider payments system in the area. This will be done in stages. In the first stage, the chief doctor of the district will manage all budgets together. Incomes for general practitioners will then be paid out to them on a capitation basis. This is in line with a national order which introduced a payment for every 100 patients registered but without introducing open enrolment (free choice of doctor) (16). The process of restructuring from inpatient to outpatient care is possible because the plan and budget are developed for the *etrap* as a whole. Later, polyclinics and general practitioners will be given their own budgets to manage. At this point it will no longer be appropriate for the *etrap* hospital director to supervise the entire planning process and an overall *etrap* planning process will be required.

For secondary care, the previous year's expenditure, adjusted for inflation, will initially form the basis of a global budget. In recent years there has been a substantial divergence between planned budgets, established at the beginning of the year for public services, and actual expenditure. The latter has been significantly and consistently less than the former as a consequence of lower than anticipated tax collections and expectations of expenditures that are unrealistic, given the current revenue base. A global budget that is realistic has to be based on actual expenditures rather than on promised budgets.

The annual budget is established by the Ministry of Health in consultation with the local

administration. Once the total is established, the hospital will be asked to show how it will spend the budget according to the conventional planning line items. This division will be the culmination of a business planning process that links anticipated spending to activities and overall provider objectives. The plan and accompanying budget must be approved by the Ministry of Health and will form the basis of budget monitoring during the year.

Financial monitoring will be facilitated by the hospital statistician who will prepare quarterly reports that show expenditure and activity compared to the same quarter in the previous year. During the year the hospital will be permitted to diverge by up to 10% from the spending on a line item without consultation. Larger divergences must be justified and approved. Some variation in activity (numbers of patients treated) from the plan will be permitted. Increases in activity of up to 10% will be rewarded by a marginal payment equal to the variable costs (food and medicines) for each patient treated. Beyond this, no extra payment will be made. Small reductions in activity will be permitted, but any fall of greater than 5% must be explained and some loss of funding result. These intra-year variations do not preclude the hospital from planning to reduce (or increase) the number of patients hospitalized. For example, this could be part of an active strategy to treat more patients at the outpatient level. These strategies will be included in the business plan and so be approved before the start of the year.

In addition to financial and activity audits, the planning process will also monitor qualitative goals. These include targets for extending antenatal care, maintaining stocks of essential drugs and financial targets for maintaining capital equipment. These will be monitored as part of the business planning process and help to counter the charge that global budgeting is not concerned with the quality of services.

The *etrap* business plan

The business planning process and quarterly reporting of activity and financial data are intended to satisfy the accountants who control the use of public money, persons who are concerned that quality of care may suffer, and policy-makers who are involved in the general restructuring process as part of government policy.

At the end of 1998, we facilitated the development of a business plan through a process of consultations with senior staff in the hospital and other health care facilities in the district. The central part of this exercise was a morning briefing session and afternoon workshop to which department heads, heads of primary care units, the hospital statistician and senior nurses were invited. A series of tables that illustrated the types of patients treated in hospital during the previous year were prepared by the hospital statistician and some of these tables formed the basis for motivating the workshop discussions.

The business planning process followed a similar format to that described by Austin (17).

The workshop began by focusing on the main purpose of the Tejen *etrap* health services. This was the first time that district officials had examined their own goals in relation to health care. The main discussion centred on whether activities should focus on the health of the population or on health services for patients. The final agreed purpose was to “make a healthy life for the people of Tejen”, laying emphasis on those who could benefit from health care but do not currently use the health services.

Information records at the *etrap* level on activities and finance follow a similar pattern to those kept by almost any health care provider under the Soviet Semashko system. Larger hospitals have some computer records, while smaller ones, such as the district hospital of Tejen, maintain paper records which will be entered on a computer at a higher level in the system. While data are generally quite comprehensive, there are two weak spots in terms of analysis of activities. First, data on expenditure and medical activities are collected and used separately — no comparisons are made between resource use and patients treated at any level of the system. Second, that data on utilization by different groups are not available. In particular, the important differences in how services are used by different age groups cannot be routinely analysed because there are only two groups: over-14-year-olds and under-14-year-olds. Nevertheless, data submitted prior to the workshop helped to indicate detailed use of services by age group. Workshop participants were then asked who they thought should be the main beneficiaries of the service (target groups) and these were then compared with the actual pattern of use.

The users of services were predominantly in the 15–44-year age group (Table 2). This is not surprising since two-thirds of admissions are for obstetrics and gynaecology and a clear gender difference is apparent for this age group (see Fig. 1). The gender differences in use largely disappear when bed-days rather than number of admissions are compared. This is because male admissions in this age group are largely for conditions such as tuberculosis, drug addiction, and psychiatry that require relatively long stays in hospital.

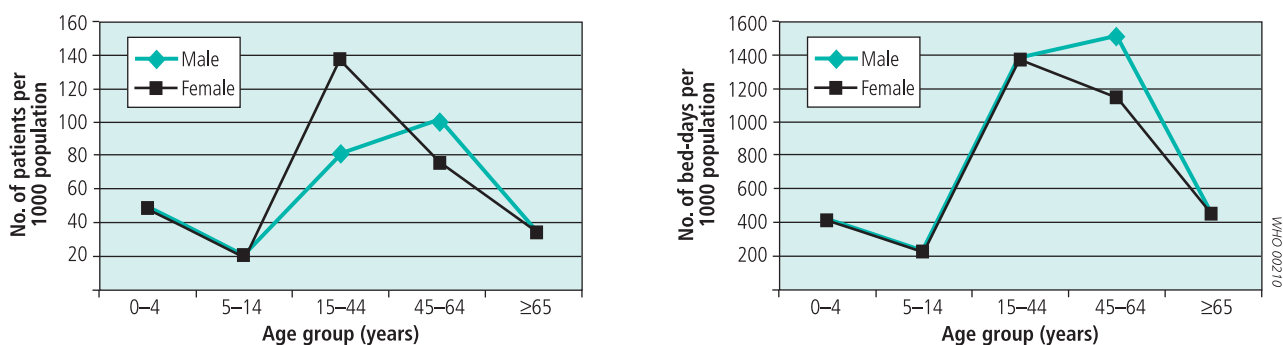
Compared to their size, the other group that makes disproportionate use of services is 45–64-year-olds among which the majority of admissions and bed-day use are men. Closer examination of the data reveals that these admissions were predominantly for treatment in the cardiac and ophthalmology departments, where the admission rate for males is twice that for females. Since this was the first time the age breakdown of patients had been examined closely in Tejen *etrap*, this finding came as a surprise to the chief doctor. Later discussions with the head of the ophthalmology department suggested that the most likely explanation was the high incidence of eye injuries among working men. These injuries often occur because the men do not wear adequate eye protectors when working with industrial or agricultural machinery. It immediately suggests a role for the hospital to promote health and safety at work, which has a direct impact on its resources.

Another feature that is apparent from these data is the low use (in absolute and relative numbers) of hospital services by over-65-year-olds. Although no data were available to verify it, a similar pattern may also be apparent at the outpatient level. This finding is in contrast to the pattern found in most countries — both rich and poor — where older age groups make disproportionate use of health services (18). In Turkmenistan the main reason provided for this pattern was that the elderly preferred to be sick at home and treat their own illness, although there was a suggestion that older patients may be put off by the high unofficial payments or were discouraged from using the services by health staff.

Table 2. Use of facilities and population structure, by age group, Tejen *etrap*, Turkmenistan

Age group (years)	Patients (%)	Bed-days (%)	Population (%)
0–4	11.1	7.6	16.1
5–14	7.0	6.7	26.2
15–44	69.1	70.5	44.0
45–64	10.2	12.3	8.0
≥65	2.6	2.9	5.7
All ages	100	100	100

Fig. 1. Number of patients and bed-days, by age group (years), Tejen *etrap*, Turkmenistan



The workshop participants were then asked to focus on the groups they thought the strategy should target. This was based on two principles. First, groups that are judged to benefit from relatively low-cost interventions and so should be encouraged to use the services. Second, groups already making extensive use of services but for whom other approaches might reduce their use of resources. Those falling into the first group included under-1-year-olds with infectious and perinatal diseases and women of reproductive age (not just pregnant women). In the second group were middle-aged men and all men with addiction-related problems. After obstetrics, this group represents the highest spending category on an expenditure per capita basis.

Objectives of the plan

The objectives of the plan should show how the purpose of the health organization will be advanced during the year in relation to its main target client groups (19). Two sets of objectives were defined (focusing on better mother and child health care and improving the general level of primary care) and it was suggested that the organization should concentrate on the following five main primary objectives during the next year:

- reduce the admission of children to hospital where medically possible;
- increase the speed of admission and the quality of care for children in hospital;
- improve the knowledge about and supply of family planning;
- improve women's knowledge about reproductive health;
- improve the sustainability of investments.

The last of these objectives was in response to a recognition that while much investment goes into new equipment and buildings, these are hardly maintained. In 1997, only about 0.2% of expenditure went on repairs and maintenance of equipment and buildings. In the context of potential investments by international agencies such as the World Bank and WHO to advance health objectives, the sustainability of these investments is a particularly important issue that should not be ignored.

None of these objectives is revolutionary or significantly different from the general tenets proposed elsewhere. Yet the process that led the staff who participated in the workshop to these conclusions could prove important to the overall success of the objectives and the strategies for achieving them.

In addition, the following secondary objectives — targeted at the slightly longer term — were suggested:

- increase the awareness of risk factors relating to heart disease among the population;
- develop strategies to address the drug and alcohol problems of the district;

- increase the use of health facilities among the elderly;
- reduce the number of workplace injuries, particularly in relation to eye injuries, through joint initiatives with local employers.

Strategies and activities for implementing the business plan

In the absence of practical strategies for implementation, the objectives identified — although important — will merely remain good intentions. Consultations with the chief doctor and other senior managers identified a matrix of strategies for each objective that could be accomplished in the short term (one year) and medium term (years two and three). A detailed action plan indicating when the strategies would be implemented and identifying the persons responsible was also drawn up by the chief doctor.

Strategies to address the dual objectives of treating children outside hospital, where possible, but getting emergencies to hospital as soon as possible were aimed at improving the quality of diagnosis and access to essential drugs at the primary level. This was required particularly for diarrhoeal disease which, in a region where the temperatures regularly exceed 40 °C and where the supply of potable water is generally poor, can assume epidemic proportions during the summer months. In the longer term it is intended to train primary care doctors to become high quality general practitioners. In the short term it was suggested that hospital staff provide on-site clinics and advice workshops for both primary care staff and parents on the detection and treatment of common diseases. Small financial bonuses may be paid for this work.

In order to improve reproductive health care — particularly important given the high maternal mortality rate — a number of activities were suggested, e.g. in common with strategies for treating child health problems, to make use of hospital specialists in the community to provide improved advice on birth spacing and family planning. In investment terms, the purchase of an additional emergency vehicle would increase the number of obstetric emergencies that could be taken to the district hospital for treatment.

The general objective of improving the sustainability of investments is to be addressed through the development of a 10-year plan, indicating the expected replacement dates for equipment and providing a budget allocation for repairs and maintenance.

Financial implications and impediments to change

The final part of the plan identifies the resources required for its implementation. This was prepared in the form of a budget request to the Ministry of Health, indicating how a global budget would be

spent and justifying the main allocative changes on the basis of the strategies described above.

One of the most difficult aspects was for the chief doctor and accountant to link the strategies to the budget requests. Much of this difficulty appeared to arise because they were used to receiving the budget on the basis of input norms, not desired activities. It is not surprising then, that the end result was a budget that did not diverge too far from the previous year's expenditure allocation. Radical re-allocations could have destabilized the process and caused the administrations at local and national levels to question whether the devolved budget autonomy was a good thing. The largest item, staffing, which accounted for around 60% of expenditure in 1998, was reduced slightly, although it is intended that there will be a larger reduction in hospital staff in the medium term. The use of staff is likely to change more dramatically because the short-term response to the main objectives is to use hospital staff to train and educate primary care staff and families. This strategy, a variation on the integrated hospital in the community concept, is not without its problems and it remains to be seen how well hospital staff will adapt to the role of community educators (18).

The main changes in the budget request were to allocate more funds to repairs and maintenance (from 0.2% to more than 5% of the budget) and medicines (from 14% to 16.5%). The latter increase was to ensure a ready supply of essential medicines for childhood illnesses. These are funded from the small reduction in staffing expenditure. This budget will now form the basis for monitoring expenditure during the financial year 1999–2000.

Critical success factors are those that are crucial for the implementation of the plan. The most important ones identified during the planning process related to the flexibility in the use of budgets. In particular, the theoretical power to allocate funding between budget lines must be converted into a reality. Two factors mitigate against this.

The first is that the hospital still has no bank account and any cash it requires must be released by the local administration.

The second is more subtle and possibly more fundamental. This is that for items other than staffing, most transactions are carried out on a non-cash basis through a process of mutual debt settlement. Most government institutions at national and local level have planned budgets but no cash. In order to obtain an item they must first identify a third organization that has a debt with the agency that allocates its own budget. The debt of the third organization is then wiped out when the item is procured and an expenditure is recorded. A key problem is in finding an organization that can both provide the item and has a debt with the funding agency. For an *etrap* to obtain repairs to the building, for example, it must identify a company that can do the repairs and also owes money to the local government administration. Sometimes, particularly towards the end of the year, when budgets must be spent, the hospital must accept the second (or

third) best on offer because the right type of creditor cannot be found. For example, it may accept a piece of equipment rather than a repair, or a consignment of vegetables and not meat. This problem could severely hamper the rational planning and allocation of the global budget.

Conclusion

To the best of our knowledge, this was the first business planning exercise to be undertaken in any *etrap* of Turkmenistan. The exercise helped to clarify the objectives of the *etrap*, while establishing some baselines for monitoring the new global budgeting system.

It is important not to overestimate the success of the process or underestimate the steps that need to be taken now. The strategies and resource implications do not represent a radical departure from the past pattern of resource use. A number of reports have recommended considerable restructuring of the hospitals sector, involving significant reductions in the length of stay in hospital, and a transformation of the primary care sector (7, 18). The reallocation of staff to primary care and overall reductions in personnel imply major staff changes. The business plan represents the beginning of this process or, more accurately, a formalization at the local level of a process that has already begun. For the process to be successful, it is important to repeat the planning exercise on an annual basis, and also to increase the time horizon of each plan. In this first attempt it was difficult to get managers to think ahead more than a year (or even six months). A plan focused on the next one or two years, but also looking ahead to the next five years, will be required in order to prepare for longer-term restructuring.

Finally, the process might be used as a vehicle to improve the management capabilities of the district facilities. This business planning exercise requires health facilities to examine their activities in a completely different way from that required by top-down normative planning. The experience in Tejen shows that it does not take much to encourage fresh and fundamental thinking. Encouraging health managers to concentrate on the central purpose and objectives of their services could become the focal point for the development of modern management skills. ■

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Résumé

Recours aux méthodes de planification des activités pour surveiller les budgets globaux de la santé au Turkménistan

Après avoir subi bien des changements, le financement des soins de santé dans les pays de l'ex-Union soviétique montre désormais des signes de maturation. Peu après la période de transition économique par laquelle sont passés ces pays au début des années 90, l'élaboration de systèmes d'assurance et de systèmes de paiement d'honoraires à l'acte a été au centre des discussions sur la réforme du secteur de la santé. A présent, on met de plus en plus l'accent sur des paiements ajustés en fonction de la composition de la clientèle dans les grands hôpitaux et sur des budgets globaux dans les hôpitaux de district plus petits. Le problème est que l'on se méfie souvent de ces systèmes qui ne permettent pas un contrôle financier suffisant. Par ailleurs, à moins d'introduire une autre restructuration planifiée, les systèmes de paiement ne peuvent pas à eux seuls permettre le changement

fondamental qui est nécessaire dans le système des soins de santé.

A Tejen, un district du Turkménistan, les plans d'activités prospectifs, qui relient des objectifs et des activités planifiés à des allocations budgétaires, fournissent un cadre dans lequel fixer et surveiller les dépenses budgétaires. Les plans peuvent être reliés à des objectifs de restructuration générale et être utilisés pour assurer une gestion financière saine. Le système de planification des activités économiques exige un changement radical de la façon dont les établissements de santé examinent leurs activités et pourrait être utilisé pour mieux faire prendre conscience des problèmes de gestion. Il peut également permettre de satisfaire les impératifs d'une planification des ressources financières rigoureuse et partant de la base.

Resumen

Utilización de métodos de planificación empresarial para vigilar los presupuestos globales de salud en Turkmenistán

Después de numerosas transformaciones, el financiamiento de la atención de salud en los países de la antigua URSS parece estar adquiriendo cierta madurez. Poco después de la transición económica ocurrida en esos países a principios de los años noventa, el desarrollo de sistemas de seguro y de pago por servicio dominaron los debates sobre la reforma sanitaria. En la actualidad se insiste cada vez más en que en los grandes hospitales los pagos se ajusten al perfil de casos («case mix»), y en que los pequeños hospitales de distrito utilicen presupuestos globales. El problema es que esos sistemas a menudo suscitan recelo porque no aseguran un control financiero suficiente. Al mismo tiempo, a menos que se avance en la reestructuración planificada, los sistemas de pago no pueden, por sí solos, inducir el cambio fundamental que precisa el sistema de atención de salud.

En Tejen, un distrito de Turkmenistán, los planes prospectivos de tipo empresarial, que vinculan las actividades y los objetivos planificados con las asignaciones financieras, ofrecen un marco para el establecimiento y la vigilancia del gasto presupuestario. Los planes pueden vincularse a objetivos generales de reestructuración del sistema y pueden utilizarse para asegurar una gestión financiera adecuada. El proceso de planificación empresarial obliga a los servicios de salud a examinar sus actividades de forma radicalmente distinta, y podría utilizarse para aumentar el grado de conciencia respecto de los temas de gestión. Puede representar asimismo una alternativa para satisfacer los requisitos que exige una planificación de los recursos financieros rigurosa y dirigida de abajo arriba.

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