KEYS TO HEALTH SYSTEM STRENGTHENING SUCCESS: LESSONS FROM 25 YEARS OF HEALTH SYSTEM REFORMS AND EXTERNAL TECHNICAL SUPPORT IN CENTRAL ASIA

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Abstract—Due to their shared history under the Soviet Union and similar health systems, countries in the Central Asia Region offer an important opportunity for the analysis of health system reforms. Building on extensive documentation of health reforms in the region, this article draws on information from a key informant virtual focus group and uses a systematic health systems framework to compare the national health reforms that Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan implemented. This comparison across the five countries captures variations in their approaches to health system reform. In alignment with health needs shared by the five nations, most country reforms and external investments focused on strengthening primary care, benefit packages, and institutional capacity. The comparison shows that of the five countries, the Kyrgyz Republic underwent the broadest, most sustained, and most successful health sector reform in the region. Though the Kyrgyz Republic enacted many reforms that were similar to those in the other countries, it was unique in implementing a comprehensive set of health financing reforms. This article also provides lessons based on external investment made by the donor community in this region’s health reforms. Three implementation factors are identified as critical to making the external investment in the Central Asia region effective: sustained and coordinated external support; early and frequent investment in national ownership; and utilization of a sequenced, pragmatic approach. Based on analysis of the shared experiences of these countries and their supporters, the article offers lessons for other countries undertaking health reform.

INTRODUCTION

Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan (referred to here as the Central Asia Region) are five independent nations that were part of the Soviet Union and, as a result, inherited the same underfunded
Semasko health system and high levels of human capital in health at independence in 1991. Despite these similar starting points, the last 25 years have seen differences across the countries in the ways in which the health sector is financed and regulated. The Central Asia Region offers lessons on different approaches to reforming and strengthening health systems. It is rare to have, and therefore important to study, a set of national health programs as they navigate change from a very similar starting point.

Another rare and important characteristic of the health systems of the Central Asia Region is the sustained and well-coordinated donor and technical partner support they received. In Central Asia, United States Agency for International Development (USAID), World Health Organization (WHO), the World Bank and a number of bilateral donors have collaborated effectively in supporting the countries in their health system strengthening efforts since almost immediately after the countries became independent. The external aid was initially started with the same team of donors and technical advisors, and same initial approach to reforms for all five countries. As countries moved in different directions or degrees, the teams and the aid packages adapted. This article looks at the variation in how the five countries each responded to external assistance in the last 25 years, and the processes followed to achieve positive outcomes in different dimensions of health system performance.

The successful implementation of health system strengthening has been detailed and recorded through many project documents, especially those funded by the USAID. Country-level statistics show dramatic improvements over the last 25 years in maternal mortality, HIV/AIDS, tuberculosis (TB), malnutrition, and cardiovascular disease. Though such health outcomes were likely influenced by health system strengthening investments, external factors related to economic and overall development in these countries have undoubtedly also played a role. This article does not attempt to identify the causal pathway for these improvements in health status but instead focuses on identifying the approaches taken over 25 years of health reform efforts and identifies characteristics that commonly appeared in the various approaches. The authors hope that sharing these characteristics will be helpful to other countries undertaking similar reforms.

**Sectoral and Historic Context**

Under the Soviet planned economic system, health care was publicly owned, funded, and managed. In reality, and in most former Soviet Republics at independence, the health system was highly fragmented in how it was financed, with all levels of government funding and managing their own decentralized health systems. This contributed to fragmentation in all five countries, because services were delivered through a number of Soviet-era structures established by government to manage specific diseases. The result by the 1990s was separate administrative structures and redundant sets of personnel for inpatient and outpatient services in nearly every oblast (regional administrative divisions) for TB, sexually transmitted infections, obstetrics/gynecology, psychiatry, drug abuse, and oncology in all five countries. A patient with multiple conditions, even if related, would have to visit several facilities to receive care. Men, women, and children were served in separate policlinics. Patients often repeated tests and exams at different levels of the health care system and in different types of facilities.

This fragmentation produced high levels of inefficiency, high overhead costs, redundant structures and staffing, and inconvenience for the health care–seeking populations in all five countries. Clinics and hospitals were inadequately equipped. Doctors’ and nurses’ university training was largely theoretical, resulting in clinicians following outdated, codified clinical practices, many of which had been developed in Moscow decades earlier. For example, most TB sanatoriums in the West closed down in the 1950s as antibiotics became available to treat TB and treatment could take place on an outpatient basis. But in the Soviet Union, TB patients continued to be hospitalized for their full course of treatment—often for more than a year. This was an enormous and unnecessary cost burden for the system and the patients in all five countries.

As the region of the Soviet Union with the lowest levels of economic development, this legacy of fragmentation and inefficiency was most strongly felt within the Central Asia Region. This was further exacerbated by the Soviet Union’s dissolution, which presented massive economic challenges to the five newly created countries. The dissolution resulted in financial starvation for the struggling health sector and ultimately reinforced a fragmented system with redundant facilities and staffing, outdated clinical guidelines, and chronic underfunding, all of which contributed to bad health outcomes and frustrated the aspirations of the population. Change and modernization were needed.

It is important to note that though the health systems inherited from the Soviet Union were similar in each of these five countries, there are some important differences among the countries in terms of their health systems and human capacity at the starting point, as well as their economic
development trajectory since independence. Two of the countries, Kazakhstan and Turkmenistan, have economies driven by natural mineral resources and are moving up the economic development scale. The Kyrgyz Republic and Tajikistan, on the other hand, are relatively poorer and do not have mineral wealth prospects. Uzbekistan is also relatively poor despite having some mineral prospects. Table 1 shows the different characteristics of these countries using the most recently available data. The table shows that, in addition to variation in gross domestic product (GDP), the countries have very different population sizes, levels of unemployment, and human capacity development indexes. The countries have also devoted different portions of their GDP to their total health expenditure, and citizens pay widely different amounts out of pocket for health services. These variations between countries show that the countries undertook reforms with differing capacity and ultimately made different decisions in their commitment to financing health.

METHODS

Literature Review
The authors conducted a search of the literature to identify the range, diversity, and similarities of health system strengthening reforms conducted in Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan over the 25 years since independence in 1991. The review of peer-reviewed publications identified a limited number of publications, with Kazakhstan receiving the most coverage. To address the paucity of information available in the published literature, the authors extended the search to the grey literature to identify WHO reviews and project reports from USAID, World Bank, and other bilateral donors. The bulk of the information in the grey literature was from USAID projects; the authors identified annual and final project reports and mid-term reviews for each of the five USAID health system strengthening projects undertaken over the 25 year period. The authors reviewed both the published and grey literature to identify the types of reforms undertaken, as well as the approaches and challenges faced.

Key Actors Virtual Focus Group
To supplement the findings from the literature review, the authors facilitated a virtual focus group discussion between key actors working within the region over the 25-year period covered by this article. The Central Asia Region has been supported since 1991 by external partners from three funding and technical agencies. Other bilateral donors and technical agencies also played a role in the region, but the three that provided continued technical and financial support over the past 25 years were USAID, WHO, and the World Bank.

To learn about the long-term engagement of the development partners, strategies implemented, and why there were both similarities and differences in health sector performance across countries, the authors identified 15 long-term staff and consultants from USAID, WHO, and the World Bank. Three criteria were required for participation:

1. Worked in or on Central Asia health reforms for at least a portion of the 25-year period covered in this article.
2. Achieved a level of seniority and responsibility that provided access to information about how the countries made decisions in the health sector.
3. Agreed to participate in the study.

Though the ideal approach would have been to gather all the relevant experts and to conduct an in-person focus group discussion, this proved too challenging given the varied locations and availability of these experts. An alternative would have been to do key informant interviews. However, the authors rejected this option because it would have eliminated interaction among the experts and forced interpretation by the authors. The authors opted instead to conduct a virtual focus group. The authors asked two open-ended questions on an open email chain that included all 15 respondents. The questions were as follows:

| Country         | Population | GDP per Capita, Current USD | Total Health Expenditure, % of GDP | Out-of-Pocket Expenditure As % of THE | Unemployment (%) | Human Development Index |
|-----------------|------------|-----------------------------|-----------------------------------|---------------------------------------|-----------------|-------------------------|
| Kazakhstan      | 17,797,032 | 7,510.1                     | 4.4                               | 45.1                                  | 5.2             | 0.794                   |
| Kyrgyz Republic | 6,082,700  | 1,077.0                     | 6.5                               | 39.4                                  | 7.7             | 0.664                   |
| Tajikistan      | 8,734,951  | 795.8                       | 6.9                               | 61.7                                  | 10.8            | 0.627                   |
| Turkmenistan    | 5,662,544  | 6,389.3                     | 2.1                               | 34.8                                  | 8.6             | 0.692                   |
| Uzbekistan      | 31,848,200 | 2,110.6                     | 5.8                               | 43.9                                  | 8.9             | 0.701                   |

TABLE 1. Central Asia Region Comparative Indicators
1. What, in your view, were the best successes for health systems interventions in the Central Asian Republics?
2. What were the main drivers for success (particularly those that are potentially replicable elsewhere)?

Respondents replied to the two questions with their individual responses, copying the other experts. The authors then facilitated a virtual discussion in which the various responses were discussed and either disagreed with or validated.

Similar to in-person focus groups, a primary concern with this approach was that a dominant voice might influence the responses. Asynchronous facilitation was used to mitigate risk of a dominant voice or group think, and the facilitators strove to draw responses from each other’s work, the email exchange was both frank and thoughtful. This article reflects the findings that achieved the greatest level of agreement among the experts, although not always full consensus.

RESULTS

Types of Health System Reforms Implemented

There have been varied health system reforms in the Central Asia Region since independence. When reforms began more than 25 years ago, few models existed to guide the comprehensive health system restructuring required in the region. However, the reforms ultimately pursued by the countries can be retrospectively aligned with models developed later, most notably the flagship framework depicted in Figure 1. The flagship framework clusters reforms into five “control knobs.” The knobs, which include financing, payment, organization, regulation, and behavior change, represent the primary areas in which policy makers can effect change in order to achieve intermediate performance measures such as efficiency, quality and access, and ultimately improved health status, customer satisfaction, and financial risk protection.

As shown in Table 2, over the 25-year period studied, the major reforms selected by the Central Asia countries were focused on three of the five control knobs. Although not an exhaustive list of reforms undertaken, the table shows considerable variation as well as some repeated patterns in the reforms selected and implemented across the region. Although it is impossible to determine exactly how each reform was selected, some similarities are likely due to uniform input from donors. Where countries moved in different ways or to different degrees likely reflects the influence of country-specific politics.

As would be expected, countries prioritized interventions in the control knobs linked to their primary pain points: organization, regulation, and financing. Two control knobs, payment and behavior change, received little or no explicit attention. Only the Kyrgyz Republic, which undertook the most comprehensive health sector reforms, addressed payment mechanisms.

Of the other three control knobs, organizational and regulatory reforms dominated. Given the structural inefficiencies, redundant institutions, and limited strategic management present within the health systems of these five countries, at the end of the Soviet Union, focusing on organization and regulatory reforms was a sensible starting point. The types of reforms in these areas were quite consistent across the five countries. The countries prioritized building institutional capacity, shifting to stronger evidence-based care and strengthening accountability systems, including information systems. Examples of newly developed institutions include ones critical to quality improvements, such as independent primary health care (PHC) providers, policy departments within ministries of health, evidence-based medicine departments and centers, and independent organizations.

The third area of focus was financing reforms. Though health system reforms under organizational and regulatory headings were popular across the region, reforms that addressed health financing and provider payment were less common. This pattern may be explained by the relative political and technical difficulty of reforming health financing compared to other types of reforms. Most financing reforms were undertaken within the context of a shift to PHC, and the Kyrgyz Republic undertook the most comprehensive financing reforms.

Focus on Strengthening Primary Health Care

Across the region, all five countries focused on reorienting and strengthening PHC. External support agencies termed this approach “inverting the pyramid,” shifting the bulk of clinical care from hospitals to lower-cost primary care. This focus makes a lot of sense given the emphasis on specialization under the Soviet health system. Whereas most Organisation for Economic Co-operation and Development countries drastically shifted away from hospitalization and highly specialized hospitals earlier in the 20th century, the Soviet Union never made that shift, leaving the newly independent republics with an inefficient service delivery model that did not match the epidemiological transition to noncommunicable diseases. In the face of extreme resource limitations after separating from the Soviet Union, making a shift to PHC promised
valuable cost efficiencies to the new countries. PHC, therefore, became a primary rallying point around which integration and sequencing of changes occurred for the control knobs used in health reforms in all five countries.

The goal of redirecting resources from more costly hospital care to PHC led all five countries to sequence improvements to their health financing systems. Pooling of resources was selected as the critical first step in the sequence because of the fragmented nature of financing under the Soviet system. Pooling, or creating a single pot of money, was done at the oblast (sub-national) and national levels. Pooling meant that, for the first time, the governments could spread risk across a larger population of both sick (high cost) and healthy (low cost) citizens, across age groups, and across geographic areas.

In many instances, planned health financing reforms required integrating other control knobs into the health reform strategy. In Kazakhstan, the Kyrgyz Republic, and Tajikistan, a benefit package for health services was either established or clarified (in Tajikistan, the benefit package was only piloted). Though Table 2 lists that intervention under health financing, any work on benefits packages goes beyond costing and financing and requires integration of reforms in the other control knobs, as well as service delivery mechanisms and the use of evidence and information.

Another essential early step was the introduction of diagnosis-related groups to drive efficiency improvements within hospitals. The use of diagnosis-related groups began to facilitate a shift away from hospitals to lower-cost PHC centers, precipitating a need for increased PHC clinical capacity. In anticipation of this shift, countries and externally supported projects built into their implementation sequence increased investment in PHC clinical training.

In reflecting on the role of PHC in driving the reforms, many of the experts who participated in the virtual focus group noted an important link between system strengthening and outputs. Namely, health system strengthening needs service delivery improvement to succeed and, conversely, service delivery improvement needs health system strengthening to be sustainable. Within the post-Soviet systems, health financing reform was a precondition for achieving PHC and for the associated requirements of restructuring of excess hospital capacity, creating savings, and retaining and reinvesting savings in direct patient care. The shift to PHC also drove other service delivery improvements, including introduction of evidence-based medicine, development of quality improvement mechanisms, integration of vertical systems and programs, and extension of services to population and community involvement.

**Kyrgyz Republic Health Financing Reforms**

Project documents, the published literature, and the expert virtual focus group findings all showed that the Kyrgyz Republic underwent the deepest and broadest health sector reform of the five countries over the 25-year period covered between 1991 and 2015. The Kyrgyz Republic achieved this despite facing a challenging political environment, including political instability, ethnic conflict, and relatively low levels of national income.

Unique among the countries included in this analysis, the Kyrgyz Republic went far beyond organizational and regulatory reforms to implement a comprehensive set of health financing reforms. The country’s health financing reforms are among the most advanced in the whole of the former Soviet Republics, not just in Central Asia, and are globally regarded as best practice. Whereas most health financing reforms in low- and middle-income countries have relied on additional, external funding to health beyond standard budget allocations, the Kyrgyz Republic relied on basic budgets and budgeting...
| Kazakhstan                                      | Kyrgyz Republic                                         | Tajikistan                          | Turkmenistan                           | Uzbekistan                                  |
|------------------------------------------------|---------------------------------------------------------|-------------------------------------|----------------------------------------|---------------------------------------------|
| **Financing**                                  | Pooled budgeting at national level                      | Basic benefits package in eight     | Rural primary health care financing    |                                             |
| Defined basic benefits package                 | Pooled budgeting at national level                      | sub-regions and comprehensive       | management reforms                     |                                             |
| and comprehensive package of services for HIV  | Established mandatory health insurance                  | package of services for HIV         |                                        |                                             |
|                                                 | Per capita allocation                                   |                                     |                                        |                                             |
|                                                 | Defined basic benefits package                          |                                     |                                        |                                             |
|                                                 | comprehensive package                                   |                                     |                                        |                                             |
|                                                 | Case-based hospital payment                              |                                     |                                        |                                             |
| **Payment Organization**                       |                                                          |                                     |                                        |                                             |
| Improved human resources for health practices  |                                                          |                                     |                                        |                                             |
| Introduced comprehensive management information systems |                                                          |                                     |                                        |                                             |
| Adopted IMCI as an integrated national strategy |                                                          |                                     |                                        |                                             |
| Expanded scope for Association of Family Physicians |                                                          |                                     |                                        |                                             |
| Drug information centers                        |                                                          |                                     |                                        |                                             |
| Open enrollment for patients to see any provider|                                                          |                                     |                                        |                                             |
| Promoting rational use of antibiotics           |                                                          |                                     |                                        |                                             |
| **Regulation**                                 |                                                          |                                     |                                        |                                             |
| Institutional legal and regulatory authority    |                                                          |                                     |                                        |                                             |
| National FP protocols                          |                                                          |                                     |                                        |                                             |
| Essential drug lists                           |                                                          |                                     |                                        |                                             |
| Evidence-based medicine centers                 |                                                          |                                     |                                        |                                             |
| Birth preparedness schools                      |                                                          |                                     |                                        |                                             |
| Medical Accreditation Commission                |                                                          |                                     |                                        |                                             |
| **Behavior**                                   |                                                          |                                     |                                        |                                             |
| *IMCI = integrated management of childhood illness; FP = family planning.* |                                                          |                                     |                                        |                                             |

**TABLE 2. Health System Strengthening Reforms Implemented in Central Asia**
processes. This involved examining how budgets are formed and executed, addressing input-based rigidities, and tackling the challenging links between health sector budget functions and the national systems of public financial management.

Though all five countries developed pooling mechanisms, the Kyrgyz Republic went further in institutionalizing this reform and established the Mandatory Health Insurance Fund, a new government institution to administer the pooled funds and monitor use of the funds. The Kyrgyz Republic also led the way in reforming resource allocation in the health sector. In the health sector, money tends to follow health facilities, especially large hospitals, and because these hospitals are usually located in large cities and national capitals, resource allocation tends to favor urban areas. Recognizing this problem, the Kyrgyz Republic realigned its allocations to focus on the population and less on facility locations.

The literature and experts agreed that several unique factors contributed to Kyrgyz Republic’s successful implementation of comprehensive reforms. First, Kyrgyz Republic had greater fiscal pressure than most of the other countries, with no prospect for mineral wealth. The country’s leadership acknowledged the fiscal shortage immediately and began implementing a plan to cut health expenditures in half over the time period between 1991 and 1998. This dramatic cut contributed to high-level political support for the proposed reforms, and the support remained mostly steady throughout the reform process. The country, with donor support, also invested in extensive capacity building for mid-level Ministry of Health officials, which enhanced commitment to the reforms and therefore their sustainability. Finally, the country was careful to give the Mandatory Health Insurance Fund the time it needed to develop fully (four years) before implementing single payer reform, making the rollout relatively smooth.

Key Success Factors in External Support

As noted in the Introduction, a rare and important characteristic of the development of the health systems in the Central Asia Region is the sustained and well-coordinated donor and technical partner support they received for over 25 years. In the discussion that ensued among respondents to the virtual focus group, three dominant lessons emerged from the experience of providing external support to such comprehensive reforms over a long period of time. Though these lessons were partially reflected in the literature, they were clarified and expanded in discussion among the respondents as the key reasons that external support to the region contributed to successful changes in the health sector. These were sustained and coordinated donor support, early and frequent investment in national ownership, and an approach to implementation that was sequenced and pragmatic.

1. Sustained, coordinated external support. Almost from the first days of independence, USAID, WHO, World Bank, and other bilateral donors mobilized support to the Central Asia Region with collaboration at a level rarely seen in other parts of the developing world. An important element of this external support was continuity, with donors and technical agencies taking a long-term view even when a “project” approach was used. A second element was a collaborative approach between the many different external agencies and with national governments. Collaboration was given high priority by all partners and was sustained for a long period of time despite staffing changes in the different agencies. A final element was coordination of efforts, with a clear division of labor that played to the external partners’ strengths. For example, the highly effective USAID ZdravReform Project leveraged the World Bank’s financial investments and links to other important elements of government, like ministries of finance, to increase the effectiveness of ZdravReform’s large numbers of technical investments. USAID sustained the work through funding external and national experts to be based in the region and to support the government reform efforts. In other collaborative partnerships, WHO took the technical lead and the overall technical coordination function. The Department for International Development and a number of other bilateral donors filled important gaps identified through thoughtful engagement in the coordination mechanisms.

2. Early and frequent investment in national ownership. Though considerable external support was provided to the region, the drivers for change and implementation were the countries themselves, led by national thinkers and doers. The actual policy choices made are extremely important, but so is the process of coming to a national ownership of the direction of change. Building national ownership, however, is a long and involved process. A wide range of skills is required throughout the design, pilot, and implementation phases of reforms. External agencies invested in providing continual support, early and frequently, throughout each phase, in the form of strong technical teams that
brought global and local expertise and knowledge to bear. They also invested in providing training for Ministry of Health and other relevant government officials to build ownership within the countries for the reforms and enhance sustainability.

3. A sequenced, pragmatic approach. Though the technical teams provided by external agencies debated and discussed the best approaches to effecting change and the appropriate sequencing, for nearly all reforms a pragmatic approach was required. Respondents defined a pragmatic approach as being flexible and responsive to the fluid situations on the ground, rather than remaining attached to an ideologue or the original strategy. A good example of pragmatic sequencing is the process followed in the pooling of resources for health in the Kyrgyz Republic. Early in the reform process, the external agencies supported changes to the purchasing and provider payment mechanism in line with a plan to keep health entirely publicly funded. However, the government then made a decision to start a national health insurance system that pools resources, which made many of the changes previously made obsolete. Rather than arguing for the original plan, the external partners pragmatically adapted their technical support to align with the government’s new strategy, salvaging what was relevant from the previous efforts. The pragmatism extended to sequencing implementation. Recognizing that it would take time to build institutional arrangements to successfully launch the insurance fund, the external technical advisors supported implementation of a pool of financial data. This allowed the country to practice aspects of pooling immediately while they waited for systems to be developed to enable the shift to pooling of actual resources. In all instances, visualizing the outcomes desired, selecting a good first step and acting on it, and then remaining pragmatic and flexible in resequencing the approach as necessary were integral to success in the continually changing political environments.

Respondents noted that, although investment in national ownership and a pragmatic approach to providing technical support were essential to the success of the reforms, these approaches also contributed, in part, to the variation in outcomes seen between the countries. Kyrgyz Republic, as noted above, had a strong country commitment to comprehensive financing reforms, whereas other countries had a lesser appetite for the same. The external agencies chose to work within the countries’ preferences rather than pushing forward reforms that might not be sustained after the donor community withdrew support. As a result, aid packages that looked similar across the five countries when they first began were adapted over time.

**DISCUSSION**

Health system strengthening and reform is a challenging task for all countries, regardless of their level of development. The historic march toward universal health coverage, even in the most successful countries (e.g., Japan and Sweden), is a complex and often circuitous process. The Central Asia Region offers important insights on how health system reforms can be made effective. Working from similar starting points, with varied human capital and wealth, these five countries have undergone considerable health system strengthening reforms with mostly positive levels of success.

The countries’ selections of reforms offer important lessons from which other countries seeking to implement health reform can learn. First, the countries recognized their most pressing challenges and prioritized interventions that addressed the organizational and regulatory reforms needed to address those challenges. Second, the countries’ focus on shifting from specialization to primary care helped guide the selection of reforms. The focus on primary health care also helped drive progress on the more politically complex financing reforms. Though all five countries implemented some aspects of financing reforms, the Kyrgyz Republic’s commitment to implementing a comprehensive set of health financing reforms set the country apart. Kyrgyz Republic’s experience highlights the importance of strong political leadership and commitment to reforms, building capacity throughout the government to increase sustainability of reforms, and taking the time required to ensure reforms can be rolled out smoothly.

The Central Asian experience also provides important insights for agencies providing external technical and financial support of health system reforms. The region has received over 25 years of sustained external support for health system reform, and throughout that time frame the donors maintained close collaborative relationships and coordinated their support. The external agencies were also unwavering in their commitment to country-led reforms and adopted a pragmatic approach to providing technical and financial support that allowed reforms to move forward despite setbacks and changes in the landscape. This level of coordination and length of commitment is rare and contributed heavily to the success of the countries’ reform efforts.

Though the shared starting point of Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan was
unique, the lessons learned from their experiences implementing reforms may be helpful to other countries seeking to strengthen health systems in pursuit of universal health coverage.

NOTES
[a] Semasko Health System is characterized as compulsory universal coverage, funded through national general tax/revenue financing, and national ownership of health sector inputs.
[b] For USAID alone, support to the health sector has included the following projects: ZdravReform Project (1994–2000), ZdravPlus project (2000–2005), ZdravPlus II project (2005–2009), the Quality Health Care Project (2010–2015), and Health Financing and Governance Project (2013–ongoing).

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