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THE CONTEMPORARY TENDENCIES IN REPRODUCTIVE HEALTH BEHAVIOR OF WOMEN IN THE KYRGYZSTAN.

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REGIONAL COMMITTEE FOR EUROPE FIFTY-NINTH SESSION

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Mr Chairman, honourable ministers, distinguished delegates, Dr Danzon, ladies and gentlemen,

You sounded the alarm about the rise of chronic diseases, and again, the need for prevention. You laid the foundation for understanding the social determinants of health and tackling them through policies that valued social cohesion and protection as worthy political goals.

This turned out to be forward-looking work for the entire world. As we know, these issues are now among the top concerns for public health in every region of the world.

The health agenda for the region changed dramatically in the 1990s, as countries in Central and Eastern Europe underwent rapid political and economic transition.

Old health problems resurged or became more apparent, especially when government health spending dropped. What had previously been pockets of poverty, or pockets of problems, spanned entire countries. The close links between wealth and health came into even sharper focus.

Specific events, such as the resurgence of tuberculosis and the return of vaccine-preventable diseases, pointed to an alarming deterioration in basic health system capacity. The consequences of unhealthy behaviours became more acutely visible, again forcing a look at the social determinants of health.

The region responded to these disparities in a true spirit of solidarity. Privilege was interpreted as responsibility. Resources were made available for direct support to countries.

The agenda turned to weak health systems as a fundamental barrier to more equitable health outcomes, and tackled the need for reform. In so doing, health officials in this region took on what must be one of the most critically important and difficult challenges in public health today. You did so with discipline and rigour.

The WHO European Ministerial Conference on Health Systems and the resulting Tallinn Charter made the case that well-functioning health systems contribute to national wealth as well as health. The Charter pulled together many lines of thinking and debate into a coherent and sensible framework, with well-defined options for action

Phrases such as "health in all policies", "every minister is a health minister", and "health is wealth" have entered the vocabulary of international health development. This has happened at a time when world leaders and ministers in other sectors have been primed, by crises, to listen very closely.

This is quite a legacy.

As you in this region have noted, strong health systems are essential for weathering current

and coming storms, like the economic downturn, climate change, the influenza pandemic, and the many other global crises that our imperfect world is certain to deliver.

Ladies and gentlemen,

Let me quote from one of your documents. "Health authorities across Europe are concerned that the present economic system does not distribute wealth on the basis of values of solidarity and equity, thus hindering improvement in health outcomes."

Precisely. This is the heart of the problem. The report of the Commission on Social Determinants of Health, issued last August, includes one particularly striking statement. "Implementation of the Commission's recommendations depends on changes in the functioning of the global economy."

At the time, that statement raised some eyebrows. A review, published in The Economist magazine, praised the report's ambitions but suggested that its attempt to correct global imbalances in the distribution of power and money was basically "howling at the moon".

A month later, the financial crisis hit the world like a sudden jolt, and hit the world where it hurts the most: money. Greed seeded the financial crisis, which sprang out of control as corporate governance and risk management failed at every level of the system.

In a world characterized by radically increased interdependence among nations, mistakes made in one country or one sector are highly contagious. And the consequences are profoundly unfair.

Developing countries have the greatest vulnerability and the least resilience. They are hit the hardest and take the longest to recover.

In a sense, the Millennium Declaration and its Goals are a corrective strategy. They aim to compensate for international policies and systems that create benefits, but have no rules that guarantee the fair distribution of these benefits.

The Goals and the many new initiatives and instruments for improving health are badly needed and doing great good. But they do not address the root causes of the great gaps in health outcomes. The root causes lie in flawed policies. This conclusion, I believe, is one of the most important outcomes of the Commission on Social Determinants of Health.

Some political analysts and academics are now predicting an end to the capitalist market model and point to signs that globalization is in retreat. We hear some sweeping conclusions: blind faith in the power of market forces to solve all problems has been misplaced.

World leaders struggling to re-position the management of their economies have been advised to look to Europe for guidance. A well-managed welfare state is not the enemy of globalization. Instead, it is the saviour.

As we know, the international policies and systems that govern financial markets, economies, commerce, trade, and foreign affairs have not operated with fairness as an explicit policy objective.

Too many models for development assumed that living conditions and health status of the poor would somehow automatically improve as countries modernized, liberalized their trade, and improved their economies. This did not happen. Too many international systems have worked in ways that favour those who are already well off. In reality, gaps in health outcomes will be reduced, and health systems will strive for fairness only when equity is an explicit policy objective, also in sectors well beyond health.

Money makes the world go round. This will never change. But, as we have seen, market forces, all by themselves, will not solve social problems. The world needs to turn with a value system at the axis. We need this symmetry. If not, an already dangerous situation of vast imbalances, in income levels, in opportunities, and in health status, will only grow worse.

Leaders in sectors with far more clout that health are making a similar point. At the April G20 summit in London, world leaders called for a fundamental re-engineering of the international systems to incorporate a moral dimension and make them responsive to genuine social values and concerns. They voiced a need to invest these systems with values like community, solidarity, equity, and social justice.

While this is welcome new thinking for world leaders, this is a familiar vocabulary for public health, dating back, as it does, to the Declaration of Alma-Ata.

For once, the ironic twists of history may turn in the favour of public health. The potential of the Declaration of Alma-Ata to revolutionize the delivery of health care was cut short by an oil crisis, an economic recession, and the introduction of structural adjustment programmes that reduced budgets for social services, including health care.

Today, a financial crisis and severe economic recession have encouraged world leaders to seek the kind of value system that primary health care has always represented. Perhaps this time around, in a world jarred awake by crises, some long-standing arguments will finally be heard.

Ladies and gentlemen,

Public health had no say in the policies that seeded the financial crisis or set the stage for climate change. But public health has much to say about the influenza pandemic, how it is managed, and how its impact can be reduced.

This is one occasion when heads of state and ministers of finance, tourism, and trade will listen closely to ministers of health. This is one occasion where the need for "health in all policies" becomes readily apparent. This is one occasion when standard arguments about the

need to build up fundamental health capacities in an inclusive way will ring true.

To date, we have been fortunate in the way the pandemic has evolved. The overwhelming majority of cases continue to experience mild symptoms and recover fully within a week, even without any medical treatment.

But clinically, this is a virus of extremes. It does not seem to have a middle ground. At one extreme are the mild cases. At the other extreme is a small subset of patients who quickly develop very severe disease. Though the numbers are small, the demands on health services are disproportionately high. Saving these lives depends on highly specialized intensive care, with highly specialized equipment and highly skilled staff.

hi countries that lack such capacities, these lives will be lost.

Of course, this is true for a multitude of other diseases and health problems. Weak capacities cost lives. But this pandemic, I believe, will make the same old point in an especially visible and tragic way.

I believe that this pandemic will be a watershed event. It is taking place at a time when differences, within and between countries, in income levels, in health status, and in levels of care, are greater than at any time in recent history.

The pandemic will test the world on the issue of fairness in a substantial way. The same virus that causes manageable disruption in affluent countries will almost certainly have a devastating impact in countries with too few health facilities and staff, no regular supplies of essential medicines, little diagnostic and laboratory capacity, and vast populations with no access to safe water and sanitation.

For these populations, advice such as wash your hands, or phone your doctor, or rush to the emergency ward will have little meaning.

Let me give just one precise example. We know, from all outbreak sites, that pregnant women are at increased risk of severe or fatal infections. Increased deaths of these women, because of the pandemic, will be tragic everywhere, but most especially so in the developing world, as the numbers will be so much greater.

Already, more than 99% of maternal mortality occurs in the developing world, where it is one of the strongest indicators of poorly functioning and inequitable health services.

Since taking office, the health of women has been one of my priority concerns. A renewed commitment to primary health care underpins efforts to improve the health of women.

This relationship is starkly evident in a report on Women and Health that I have commissioned. The report, which will be issued in November, explores the many health risks that women face throughout the life course, and sets out an agenda for change.

As this region has done with health systems, we need to make the agenda for women's

health look manageable, with clear policy options, and compelling arguments for more attention and greater investment based on solid evidence.

Ladies and gentlemen,

Let me conclude with another brief expression of appreciation. Many of the countries represented in this room have played a leading role in the creation of new health initiatives for the developing world and in finding innovative ways to secure additional funds. You are also addressing the pressing need for more effective aid.

When privilege is interpreted as responsibility, we again see those values, like equity, solidarity, social cohesion and protection, that are at the heart of your contribution to better health, regionally and internationally.

Thank you.

GENDER ASPECTS OF HEALTH OF ADULT POPULATION IN ALMATY

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Gender is one of the important definitions in new public health. Gender definition bases not only on biological ideas and personal skills, but through system of social interpretations, i.e. through culture context. The most acceptable type of gender system is that consist two gender groups: male and female.

In Kazakhstan economical crisis, decreasing of living level, socio-economical transition period are negative influenced to the life expectancy in the last years, which is shortest in the EES and NIS. There is gender disparity in life expectancy between males and females. Difference of male and female indexes is increased from 9.5 in 1990 through 11.9 in 2007. This is evidence about gender problems of mortality in the country. According to republican data higher morbidity (cardio-vascular diseases, trauma, tuberculosis) and mortality levels are among men. Anemia and maternal mortality are problems for women health status.

Object of the study was to define gender peculiarities of health status and attitude to health services among population of different ages.

Subjects of the study were 1179 respondents 20 and more years old from Almaty selected by randomized method. Data analysis has been performed in SPSS program by using χ^2, SR, SI

parameters.

There are defined some peculiarities in age and gender groups on health status, women access their own health worse than men. Men noted more pulmonary diseases, trauma in the history. Women noted neurological, endocrine, kidney diseases. There are different attitude to health services among men and women. Men were more oriented to problem issues, attitude of medical workers to their professional responsibilities. Women more oriented to emotional sphere, and attitude of medical workers to the patient. Also, there is difference in health information getting. So, male respondents noted that they trust only for health information coming from medical workers, at the same time women believe to health information coming from different resources – TV, newspaper, medical workers, and journals.

Thus, gender approach in health could help to make system of medical services providing more complex from one side and more gender sensitive from other side. This would initiate to specify medical services according to each gender group needs and help to improve quality and satisfaction by providing medical care.

AN ALTERNATIVE SOLUTION TO THE ISSUES OF HEALTH CARE REFORM

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With the economic crisis of the Republic of Kazakhstan out of that situation is a serious health care reform. At the present time in Kazakhstan there is a need for an efficient financial system health. We know that without an effective quality management system of medical care, to talk about improving the quality of care is meaningless. The government faces a huge challenge to the current crisis to create a health system with which to combine the above identified problems, but it must be respected health priorities for public health [1].

The main objectives of health:

• Improving health and social welfare;
• Ensuring equity and access to health services;
• Provision of micro-and macro-economic efficiency in resource use;
• Improved clinical efficiency;
• Improving the quality of medical services and customer satisfaction;
• Ensuring long-term financial stability of the system.

Worldwide trends in health aimed at:

• Increasing demand for quality human personnel (emerging economies);

• The rising cost of health;

• Increased investment in high-tech sector, biomedical technology, research;

• International competition of suppliers (the money goes to patients);

• Globalization of labor markets (medical staff);

• Innovative technology management: PPP and concessions, horizontal networks, outsourcing, financial innovation;

• Harmonization of standards (protocols);

• Focus on outcomes (indicators).

To date, improving the quality of care - one of the priorities of the health system in Kazakhstan, as in the rest of the world, aimed at creating a quality management system of medical care, which aim to:

- Improving the process and outcomes of care;
- Cost optimization.

The condition of state economic development, social stability and is therefore one of the most important tasks of the state provision of social guarantees, including guarantees for affordable and quality health care.

Policy-makers should have a method of comparing the effectiveness of the health system of their country with the health systems of other countries or regions with comparable levels of income [2]. To do this, create an international program for standardization in different industries.

With the integration of Kazakhstan into the global economy, issues of business of great importance. Strategy of Industrial and Innovation Development of Kazakhstan calls for the introduction of quality management systems in enterprises [3].

In the State Reform and Development Program of Health of the Republic of Kazakhstan for 2005-2010 under the direction of creating a quality management system of care seeks to further improve diagnosis and treatment protocols, evidence-based medicine. Decree of the President of the Republic of Kazakhstan dated 13 September 2004 № 1438, the main task of reforming and development of public health for 2005-2010 is asked to establish minimum standards for the guaranteed volume of free medical care at the first stage, second stage of reforms to improve the quality was carried out by introducing international standards [4]. From this it follows that there is a need to improve public health standards.

Thus, to achieve the safety of treatment, clinical and cost effectiveness to management of health resources, providing for every citizen of Kazakhstan, equal opportunities for access to quality health care is necessary to establish standards of care.

One of the ways to implement the tasks is to further improve and develop the institution of standardization in the provision of medical services through the development of diagnostic protocols and treatment and the calculation of the economic part.

RECENT EPIDEMIOLOGICAL CHARACTERISTICS OF UNINTENTINAL CHILD INJURIES

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Injuries and deaths due to external causes, recognized worldwide as preventable conditions and causes of death, continue to remain the important problems of public health. A traumatism as the reason of the lethal outcome is a leading cause of death among children and adolescents. Annually accidents are the causes of about 22 million injuries, poisonings and burns and hundreds thousand fatal results among children. At the present stage injury should be considered as one of the principal hazards for child's or adolescent's life.

The burden of child injuries has unequal distribution in the world. Children who suffer from severe injuries live in the developing countries (90%). The main causes of child deaths worldwide are Road Traffic injuries (RTIs), drowning, and burns.

In 2002 RTIs killed 111,497 boys and girls under 15, 89,898 boys and 55,028 girls died of an drowning. The majority of child deaths under 15 were the result of RTIs (28%), drowning (20%), and burns (10%). As in whole world, RTIs, drowning, and burns are the leading causes of child mortality under 15 in the Republic of Kazakhstan.

In children under the age of 15 years, RTIs rank as the eleventh cause of death and the tenth cause of burden of diseases among children. In average, worldwide RTIs mortality rate is 10.7 per 100,000. For comparison correspondent rate in the Republic of Kazakhstan is 8.6 per 100,000.

Up to the present time drowning rank as the first cause of child death due to injures but now drowning yielded to RTIs. The average world mortality rate in 2004 was 7.2 per 100,000. According to the data of 2004 the Republic of Kazakhstan is a leader on child lethal drowning in the European region – 6.9 per 100,000.

Burn is a damage affecting skin or other tissues by the thermal factor. At children burns are shown more hardly, than at adults owing to the size of their bodies, thickness of skin and

mucous membranes, and time of the reaction. Burns are one of the leading causes of child mortality, child disability, and incidence in the majority of the countries. In average, mortality rate of burns was 3.9 per 100,000 in 2004. In Kazakhstan similar indicator in 2004 was 1.0 per 100,000, that in 2,5 times exceeds rates in Western Europe.

Now public health in the Republic of Kazakhstan faced with necessity to develop National Strategy on Child Injury Prevention. This process requires methodical approach and careful preliminary work to identify epidemiological characteristics of injuries, risk factors, causes and circumstances.

METHODS OF CONDUCTING THE EXPERT ESTIMATION OF THE UNDESIRABLE CONSEQUENCES OF MEDICAL INTERFERENCE

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One of the modern tendencies in the world healthcare development is the attention increase to the quality of medical care and medical service. World Health Organization pays much attention to the development of mechanisms of quality patient service supply in the healthcare system of different countries.

Coping out expert estimation card of undesirable consequences was developed.

Expert card is the card for the information gathering about the undesirable consequences of medical interference, related to reveal the mistakes of doctors, to find out the causes' arise and to establish the cause-consequence relation with the undesirable result.

Table 1 - Sample of the expert card

№	Sex	Age	Region	Diagnosis	Category of complainer	Cause of complain	Result of compliance	Expert conclusion

The information gathering is done agree to the expert laws (according to the Rules of carrying out the quality control of medical care in the Republic of Kazakhstan, approves by the f.d. of Minister of Health of KR, in 28 December in 2004, № 898) [1]. In the noted laws the expert conclusion including objective, motivational decision of object examination, on the basis

of needed medical documentation tests and the complex of other events with the aim of getting the objective data to get the expert conclusion is done.

The objects of the research are the citizens' compliance to the CCSMCP for the 2006-2008 years that get the non-qualified in-patient and out-patient medical care.

Expert card data includes the information of out-plan examination, on the basis of citizens' complaints to the non-qualifies medical care and other situations that needed urgent examination. The medical histories of citizens that taken non-qualified medical care should be analyzed (retrospective analysis).

The sufficient part of this card is to get the following information:

1. The total number of patients' complaints to the non-qualified medical care.

Total number of complaints	Revised complaints	Complaints concerned with the non-qualified medical care		
		proven	non-proven	partially proven
Expert estimation to CCSMCP in the sphere of medical care supply (for the 2006-2008 y.y.)	Total amount of analyzed complaints (with the account complaints to the proving of leaf disability and to identify the group of invalidity and so on.)	To the experts' opinion are proven	To the experts' opinion are non-proven	Medical care has the error phenomenon, which do not carry any harm (sanitary causes, food and so on).

The obligatory part of this card is to get following information:

2. column "Region" (territory) – information about the regions with the high tendency of citizens' complaints concerning to the non-qualified medical care. The increase of citizens' complaints rank concerning the non-qualified medical care among the regions shows the developing literacy of population in contrast with 3-4 years ago.
3. column "Sex" and "Age" - characteristic of sex and age of the people who were under the adverse influence of medical interference.
4. column "Diagnosis" gives the opportunity to identify the weakest medical profile which undergo the adverse influence of medical interference.

5. column “Causes of complain” – information about the infringement of medical staff to the patients.
6. column “ Result of compliance” gives the opportunity to get the data about the result of adverse influence of medical interference.
7. column “Expert conclusion” gives a chance to trace either all needed measures to the qualified supply of medical care. This index helps to value the level of complaints provement, helps identify character of error cause (objective or subjective).

Expert card helps to value the quality of the given medical help according to the following indicators of quality (in the column “Expert conclusion”):

1. indicators of resource supply (material-technical supply, stuff supply and so on.)
2. indicators of medical care process (medical care supply technology observation, sanitary- epidemiological mode and so on).
3. indicators of results of medical care supply (the influence for the health in the result of medical care supply or medical care ignore by the medical organizations and a physical person).

The noted indicators gives the chance to highlight the main causes of non-qualified medical care, which takes place in the medical organizations.

LITERATURE:

1. № 898 order of f.d. of the Minister of Health of KR “About the approving of rules of carrying out the quality control of medical care supply in the Republic of Kazakhstan”.

ABOUT INDICATORS OF THE ACTIVITES OF PRIMARY HEALTH CARE MEDICAL ORGANIZATIONS IN ALMATY

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Preliminary pylot studies on quality and accessability of primary health care (PHC) to population under the new conditions of health care system resource provision of Almaty served as a general methodical basis. Therefore, six PHC organizations in Almaty city were chosen as the main reseach subjects, including: joint polyclinics №№ 1, 5, 8 and children’s polyclinics №

3, 5, 8.

The study of accessability and quality of PHC for the population of Almaty city demonstrated that in dynamics for the period of three years (2003-2005) alongside with the growth of population of the city there was shaped a tendency for decrease of planned capacity of outpatient-polyclinic organizations (including those per 10 thousand population), which characterizes the decrease of accessability of outpatient-polyclinic care for the population.

The rate of planned capacity of outpatient-polyclinic organizations per 10 thousand popullation, as an indicator of this kind of care, decreased 126,4 per 10 thousand population, with average republican rate of 132,4. At that, the dynamics of the volume of outpatient-polyclinic care for the population, considering medical organizations of all forms of ownership and departmental affiliation, is stable – more than 10,6 mln. visits per year. The volume of outpatient-polyclinic care being rendered by governmental health care organizations, is practically stable - 8 mln. 353,2 thousand visits, including those by state order - 7 259,1 thousand visits.

It was determined, that accessibility of care by the number of visits per 1 citizen considering organizations of all types of ownership was also stable – 8,7 visits per year. In the meantime, by the governmental organizations it decreased from 7,3 to 6,8 visits per 1 citizen in a year, e. g. 6,2 visits per 1 grownup citizen (in 2004 – 6,5) and 9 visits per 1 child (accordingly 9,3).

At that, broken down medical organizations of Almaty city level of accessibility is not equal. So, high indicators were marked at the city polyclinics (CP) №1, 5, 10, 12, 13, 16, at the polyclinic of the veterans of world war, children's city clinical hospital (ChCCH) №1, children's polyclinics (ChP) №1, 4, 5, 6, 7 and low ones – at the polyclinic of periodic screenings, CP №14, city clinical hospital (CCH) №5, ChCCH №2.

The next indicator, at home visits of the population by physicians, showed it decrease from 13,7 to 12,8 visits (-6,6%). The decrease of this indicator was detected among the grown-up population from 13,5 to 12,3 visits, at the joint polyclinics from 14,3 to 12,8 and among the child population from 21,8 to 22,0.

Besides that, there was marked a decrease in appealability of the population to the territorial policlinics from 79,2% in 2003 году, to 76% in 2004, and to 70% - in 2005. At that, by the medical organizations of Almaty, as well as before, minimal medical aid appealability of the population was revealed at the Central City Clinical Hospital (CCCH), CCH №5, Family medical ambulatory (FMA) №4, and maximum - at CP №1, ChCCH №1, ChP №1, 6, 8.

The results of the study have demonstrated, that quantitative and qualitative indicators should be used in dynamics during several years (at least for the last 3 years), and this will allow

to monitor most objectively dynamic processes, which occur in the changes of the most important indicators, influencing volume, structure and quality indicators of evaluation the quality of PHC organization's activities.

TO THE ISSUE OF EVALUATION OF THE QUALITY OF REHABILITATIVE SERVICES

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The number of disabled people and the figures of the primary disability were remarkably increased recently all over the world, including Kazakhstan also. By world statistics in average about 8 million invalids are appearing annually, and each day - 23 thousand people acquire disabilities. This fact explains the serious efforts that countries are undertaking in order to solve the problems of disabled people, their medical-social rehabilitation and integration into a society, and that is why the issue of remedial treatment and rehabilitation of diseased and disabled people is the subject of international cooperation. In Kazakhstan the number of invalids was 466,3 thousand people in January 1st, 2009, or 3% of the entire population, and by UN data the number of disabled people all over the world is 10% of the population. In dynamics the intensive rate of the primary disability has a tendency to growth. By the results of 2008 this figure made up 28,2 cases per 10000 population, which is 1,8% higher than in 2007. In the age structure of invalids the persons of working age are prevailing – more than 75% (the data of statistical records by form 7).

The nosological structure of the primary disability of grown-up population is stable: 22-23% are the diseases of blood circulatory system, 17-18% - neoplasms and 14-15% - injuries. Among disabled children every third of them are suffering from congenital anomalies or chromosomal disease, in 25-26% of children the causes of disability are diseases of nervous system, and mental disorders making up 11-12%.

Existing medical-social and medical-demographical situation is caused by numerous factors, and rehabilitation is demanding a systematic and complex approach. Well-managed system of rehabilitation in the countries of West Europe, active participation of the governments of these countries, public organizations and disabled people themselves led to high level of integration of disabled people into the society. Therefore, the problems of disability are global and demand their decision on the governmental level: to prolong the years of average life expectancy without disability, increase the integration of disabled people into the society.

During the last years, despite the difficult socio-economic conditions, there were done a lot of activities related to rehabilitative care for population by our government. In relation with this in order to determine the main directions of governmental policy towards social care and rehabilitation of disabled peoples there was developed by the Government a Program of rehabilitation of disabled people, which determined the guaranteed list of activities of medical, social and professional rehabilitation of invalids and which became a basis for development of regional programs. Under this program there was expanded a network of in-hospital facilities of social care, divisions of social care at home conditions, there were increased a volume and quality of available for invalids technical supportive (compensatory) equipments, and were provided the ways for increasing the accessibility of infrastructure for disabled people. As we can see, the realization of the program resulted in increase of capacity without evaluation of expected outcomes. For realization of the Program of rehabilitation of disabled people for 2002-2005 there was planned to spend 4,6 milliard tenge, including 1,9 milliard tenge from republican budget, and 2,7 milliard tenge from local budget; for realization of the Program of rehabilitation of disabled people for 2006-2008 there was planned to spend 23179,0 mln. tenge from governmental budget, , 5129,7 mln. tenge from republican budget, and 18049,3 mln. tenge from local budget. The increase of financing in subsequent years didn't become a crucial factor in solving this problem, such a qualitative indicator as number of disabled people, who were integrated into society, remained at the same level. By the Republic of Kazakhstan the rate of total rehabilitation in the entire population at the period from 2005 to 2007 was 5,7%, and in 2008 it made up 5,3%.

Rehabilitation in our country mainly is presented by social and occupational aspects, there was accepted a Law "On special social services" from December 29, 2008, and was proposed a project on standards of the quality of social care. According to guaranteed volume of free of charge medical care of diagnostic and curative character, rehabilitative activities are often limited only by sanatorium-resort therapy and provision of technical supportive equipment. Absence of definite criteria and standards of diagnosis and treatment, of determining the reserved potential and forecast for diseased or disabled person, having its specific features, which are determined both by the status of disabled person as well as by the final goal of rehabilitation, create a number of difficulties and problems for physicians-experts. Therefore, annually developed rules and guidelines are not able to meet such a characteristic of a standards as reliability, because the results are not measurable; effectiveness, because the expected effectiveness does not measured, and the satisfaction of invalids by rendered rehabilitative care is not being assessed.

Low effectiveness of prophylactic services and rehabilitative activities in our country is

the result of the absence of methodological basis for assessment of the quality of rehabilitative care, and the absence of the modern ways of approaching the contents of disability. It is impossible to achieve acceptable quiality of life for invalids without complex rehabilitation, including medical, social and occupational aspects. Medical rehabilitation is the most important component which is determining significantly the effectiveness of social and occupational rehabilitation. This issue has a number of unsolved problems that prevent the development of disabled people's rehabilitation as a system and process, including the problems of assessment of the quality and effectiveness of medico-social rehabilitation. Untill present time the quality and effectiveness of rehabilitation of disabled people is still being judged mainly by change in groups of disability, positive or negative dynamics of pathological process, that doesn't satisfy modern concept of disability. It is hard to overestimate the practical significance of assessment of the quality and efectiveness of disabled people's rehablitation because of the following reasons: first of all, it is necessary in order to accept adequate management decisions, directed to improve rehabilitation; secondly, - for rational use of limited financial and material resources; thirdly, - for evaluation of their own efforts and it's results by executors of rehabilitation actions themselves. And this is impossible without evaluation of the quality and effectiveness of rehabilitation. One of the most perspective ways of systematic approach for quality management is considered to be a standartization, which is founded on principles of evidence-based medicine.

This important decision about standartization of rehabilitative services will have several really esssential concequences. Firstly, one of the principles of standartization is taking into account the interests and needs of a persons concerned. Secondly, there will appear a totally new class of consumers - disabled people.

At the same time, in the Programs of governmental quaratees of medical care in Russia, as well as in Kazakhstan, all over only three types of medical care are determined: hospital care, polyclinical, and ambulance and first aid. Thus, even medical rehabilitaion, despite it's long history of existence, specificity of rehabiliative process, existence of close correlations of the medical rehabilitation with other types of rehabilitation (social and occupational), is still not determined neither as a separate type of medical care nor as an independant service. More over, at the legal field rehabilitative sevice does not exist at all. This circumstance is creating difficulties not only with the choice of the optimal way of financing of rehabilitative institutions and subdivisions, but also in development of the criteria for assessment and control of rehabilitative care, of the interaction of institutions and enterprises, taking part in the complex rehabilitation of disabled people.

EXPENSES OF ONE TREATED PATIENT FOR DIFFERENT TYPES OF VISITS

TO PHC ORGANIZATIONS IN ALMATY CITY

B.Zh. Bizhigitov

City polyclinic №8, Almaty

The study of dynamics of change in unit expenditures per 1 treated patient at polyclinics has revealed that 2003 in average by the all polyclinics under the study unit expenditures per one treated patient made up 787 tenge; in 2004 they had increased by 7,9%, and in 2005 – by another 5,6%.

The average annual growth rates of the explored indicator made up 6,7%. Transformation of the achieved values into the grades system has shown that in 2004 rates of deviation from average growth rates were maximum in joint polyclinic №8 (+10,1 grades), minimal – in joint polyclinic №1 (-1 grade).

In 2005 accordingly in the joint polyclinic №8 (+4 grades) and at child polyclinic №8 (-6,2 grades). It was concluded that for integral evaluation of the effectiveness of use of unit expenditures per one treated patient at polyclinic, average annual growth rates in the range of 1,3±0,6% or 1,3-0,6 grades could be used.

The study of the dynamics of change in unit expenditures per one treated patient at day hospitals of the polyclinics has demonstrated that in 2003 average value of this indicator was 2216,6 tenge; in 2004 it increased by 3,8%, and in 2005 – by another 3,7%.

Graded evaluation of the revealed tendencies has determined that in 2004 maximum positive deviations from the average growth rates were observed at the joint polyclinic №5 (+2,1 grades); maximum negative – at the child polyclinic №5 (-2,2 scores). In 2005 these deviations were less and fluctuated in the range from +1,5 at the joint polyclinic № 5 to -1,7 at the joint polyclinic №1.

Therefore, it was determined that for the needs of integral evaluation of the quality of resources provision and resource-intensiveness of semi-hospital technologies of treatment there could be used the average annual growth rates of unit expenditures in the range from 3,0 to 4,0%.

The study of the dynamics of change of unit expenditures per one treated patient at home was conducted taking into account personal expenses of patients for purchase of medications and expendable materials, which were determined by experts and made up 45 - 65,0% in the total structure of these expenditures.

It should be mentioned that in determining the average values of studied indicators we took into account average polyclinic expenses for transportation and communication facilities. At that we were considering that these expenses should be performed from the budget of polyclinics.

Thus, such methodical approach allows, first of all, to choose from the list of selected indicators of quality of financial provision of PHC organizations the most important ones. Secondly, there were proposed new criteria for determination of their rating based on evaluation of average annual rates of their change. Thirdly, expert analysis of the revealed changes and their transformation into the grades system allowed assessing each of the indicators separately, and as a structural element of integral evaluation.

Therefore, the developed methodic, which will be used also in evaluation of other organizational-functional elements of PHC organization's activities, could be considered as unified, and allow managers and specialists to conduct complex integral evaluation of quality and accessibility of primary health care to the population.

THE EXPERIENCE OF PRIVATE HEALTH INSURANCE IN THE WORLD

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Health systems may be funded from various public and private sources and these funds can be spent on many kinds of public and personal health care. Private insurance is considered a luxury, but the queues and rationing, which are associated with some of the budget for health systems, encourage the demand for supplementary private insurance, because it provides benefits such as short waiting times, the timing of treatment, a wider choice of doctors or hospitals, and more convenience. Currently, private insurance is practiced mainly in Western European countries (Italy, Spain, United Kingdom) [1].

The development of mutual aid associations in Europe and their subsequent transformation into a unified National Health Insurance Fund has had a lasting impact on private health insurance. Private health insurance is a substitute, an additional or complementary. Types of private health insurance also differ by the method of calculation of premiums (according to individual, group or social risk), by the method of determining benefits and the status of providers of insurance services (commercial and non-profit insurers).

Replacement insurance provides an alternative to state insurance, access to this type of private insurance are those populations that may be excluded from public insurance or who have freedom of choice outside the public system. In Germany and the Netherlands, people with high incomes can buy a replacement for health insurance. Since the amount of income to some extent associated with the risk of contracting, the division of public and private insurance according to the size of income leads to the fact that persons with relatively high risk are concentrated mainly in the public sector. Those with relatively low incomes pay higher premiums to compensate for higher risk and lower middle income customers. This reduces the efficiency of redistribution of funds and gives the combination of funding mechanisms regressive.

Custom private health insurance allows faster access to services or improves the quality of "hotel" facilities in public health institutions. This may violate the principle of equal access to health services for those who use the services of private insurance and those who did not enjoy it. Supplemented by private health insurance completely or partially covers the cost of medical services that are not covered or not fully covered by the state system. Such policies covering user fees completely neutralized the impact of the latter on the utilization of services [1]. Moreover, supplementing the insurance virtually inaccessible to persons with low incomes, so these patients often have to pay the fees out of pocket. This leads to the fact that the poor have to bear the excessive financial burden [2].

Collection of private health insurance premiums can be carried out by independent private institutions - private commercial insurance companies (in most countries where there is a private market in health insurance) or private non-profit insurance companies and foundations (in Belgium, Britain, Germany, Denmark, Ireland, Italy, Luxembourg, the Netherlands, Finland,

France and Switzerland). Private health insurance may be partially subsidized by the state using tax rebates as in Austria, Ireland and Portugal. Germany and the Netherlands restricted the practice of the liberation of insurers from taxation, are not exempt from taxation of private insurers in Belgium, Britain, Denmark, Spain, Finland, France and Sweden. In most countries, private insurers to compete with the state and the system or to supplement it with private medical insurance may cover the economically unprofitable services such as dental, cosmetic, private hospital rooms, services are not included in the state plan because of unresolved management problems (cataract and hip prosthesis in the British National Health Service). In recent years, Kazakhstan has been actively developing the private sector health insurance (Interteach, Nomad, Medicare, Kazkommerts-policy, etc.), but they focus on the proportion of people working in foreign companies, embassies, banks, major oil companies, major factories and enterprises, industries related to hazardous conditions.

Financing long-term care is carried out differently. In Denmark and the UK long-term

care is mainly funded from general taxation in France is financed from social insurance contributions in Germany, operates the state diagram of long-term care, and at the end of 1990. Introduced a system of financing of social insurance contributions. In the Netherlands, medical services for the majority of the population financed social health insurance; the deficit is covered by a special government funds, and medical services for the rich part of the population - private health insurance. There is also a special fund, which finances care in nursing homes.

In the U.S., private health insurance is the only form of insurance coverage for persons not covered by government programs such as Medicare (for elderly), Medicaid (for some individuals, both within and outside of working contingent) and the Veterans Administration (for retired and active of the armed forces). Insurance is organized mainly by groups of employees (group risk assessment); prerogative of choice of insurers belong to the employer. In practice, this means that employees have at best a very limited choice of insurance company.

In recent years much attention has been paid to medical deposit accounts. Although medical savings accounts were the subject of intense debate in the literature [3,4,5,6,7], they really only apply in Singapore, but in a more limited extent - in the United States (more recently also in China). The essence of the system lies in the fact that some individuals regularly contribute a certain portion of their income on their accounts, the money is then used for medical purposes, medical savings accounts are supplemented by compulsory insurance against accidents. Specificity is determined by the traditional culture of Singapore's savings and high gross domestic product per capita [8].

U.S. President Barack Obama said in his speech, that private insurance is not available to all segments of the population at the moment because most inexpensive and a minimum package of $ 3000, not all citizens of the United States can afford this year's budget allocates about 900mldr.dollarov on the development of social medical health.

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ABOUT SALARY OF PHC WORKERS IN ALMATY CITY

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It is well known fact, that expenses for salary payments in budget organizations are the most consuming and constrain the resource's provision of the main therapeutic-preventive activities. Therefore, reduction of the weight of expenses for salary in the total volume of financing of the primary health care organizations (PHC) is the most important indicator of their financial provision.

Aim of the research. To study the dynamics in changes of expenses for salary payments in PHC organizations of Almaty city.

Materials of research. The study objects were three joint (№№ 1, 5, 8) and three child polyclinics (№№ 3, 5, 8).

Results of the research.

It was determined, that in 2004 comparing with 2003 growth rates of the weight of salary payments in the total size of financing in the PHC organizations under were differently changing.

So, at the polyclinic №1 it decreased for 13,8%, at the polyclinic №5 – almost without any changes, and at the polyclinic №8, contrary, it was increased for 22,9%. At the same time, at the child polyclinic №3 it didn't change, while at the children's polyclinics 5 and 8 – it decrease accordingly for 13,7% and 10,6% in 2005 in comparison with 2004.

At all joint polyclinics the weight of salary in total amount of financing was decreased

(accordingly for 1,4%; 10,9% and 13,3%), and at the children's polyclinics, in contrast, it was increased or wasn't changed.

The study results show, that despite the increase of the volume of financing in general, and particularly of the per capita financing, the average indicators of the weight of expenses for salary payment, during 2003-2005 were almost without any changes. This represents existence of strict regulations regarding the payments by specificities of budget classification, and strict rate setting of means devoted for salary payments.

On the other hand, obviously, that existing norm of financing medical organizations, including PHC organizations, is limiting operationability of financial resources management, preventing their saving and most rational use for decision of the priority objectives of therapeutic-preventive activities. Apparently, that alongside with increases in the total amount of financing of PHC organizations, the weight of planned resources for salary payments should be increased also. It is especially important in anticipation and introduction of differentiated salary payments, the basic requirement of which is high economical freedom of managers of health care organizations regarding the spending of the wage fund.

It is well known, that ability of planned renewal of the main funds of health organizations, including PHC organizations, is one of the indicators of recourse's provision. The study of this issue in the frame of the conducted research has shown that increases in the total amount of financing of PHC organizations of Almaty city are not accompanied by obliged increase in the weight of expenses for renewal of basic funds.

It is obvious, that application of the explored indicator for multifactor assessment of the quality of medical care will be effective in case of appearance of the real possibilities for changes in regulations of resources allocation for renewal of basic funds; additional tools and motivations for intrasystem savings of the budget resources and their reinvestment to renewal of medical-technological base of PHC organizations.

THE ANALYSIS OF CITIZENS' COMPLAINTS TO THE POOR-QUALITY MEDICAL CARE.

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Patient safety is the serious problem for the global healthcare.

In the frameworks of the scientific-technical program "Scientifically-reasonable approaches to the formation and realization of the patient safety policy management in Kazakhstan Republic" the data coping of citizens complaints for the period of 2006-2008 years in the Committee of control in the sphere of medical service of MOH of KR for the low quality of medical care supply was done.

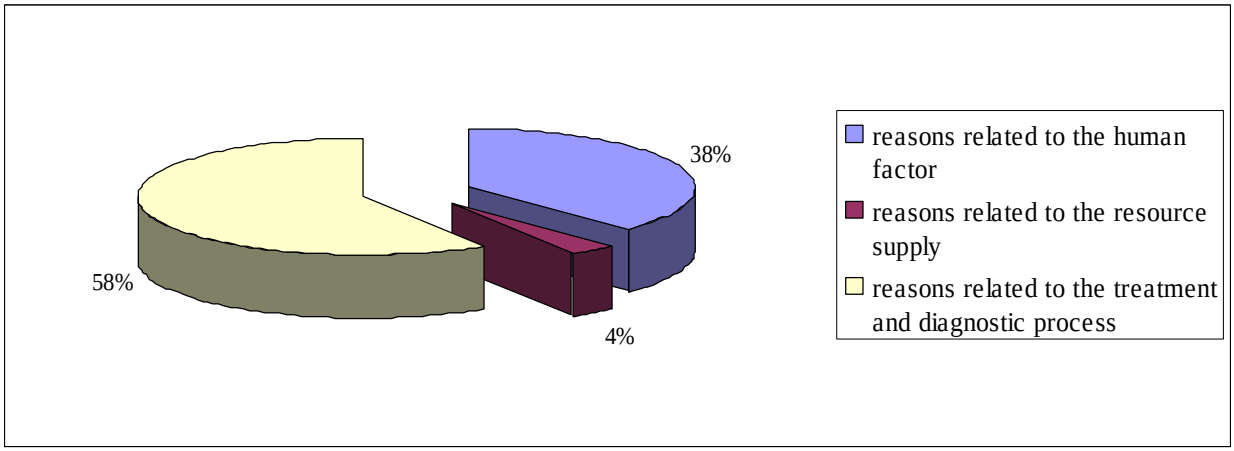
From all the amount of complains to the low medical care quality (470) 223 people noted one reasons, several reasons were noted by 246 people.

Complaints' reasons to the low medical care were divided into three groups (table 1).

Table 1 - Complaints' reasons to the low medical care

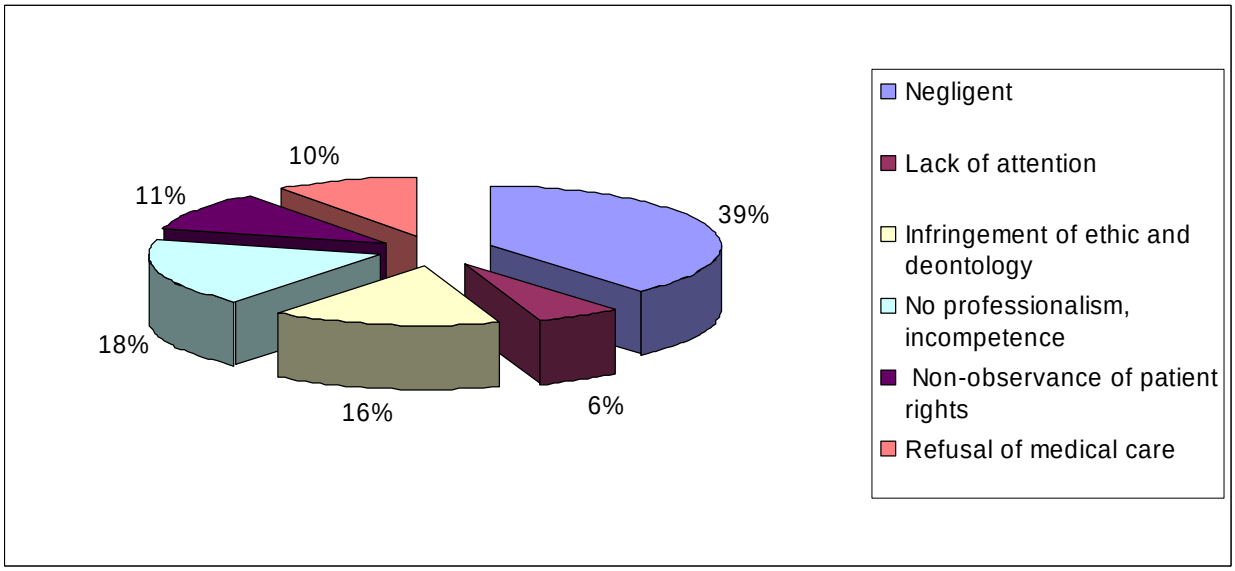
1 group reasons related to the human factor	**2 group reasons related to the resource supply**	**3 group reasons related to the treatment and diagnostic process**
1. Negligent from the side of the medical personnel 2. Absence of attention from the side of medical personnel 3. Infringement of ethic and deontology 4. No professionalism, incompetence 5. Non-observance of patient rights 6. Insufficient estimation of patient condition 7. Refusal of medical care	1. Insufficient material-technical equipment 2. Insufficient medicine maintenance (in the framework of)	1. Poor-quality of medical care 2. Untimely medical care 3. Inadequate medical care (wrong diagnosis) 4. Not fully volume of medico-prophylactic care 5. Infringement of sanitary-epidemiologija mode

The biggest amount of complaints are the reasons, related with the process of medical care itself (58%) and causes, related to the human factor (38%) (picture 1).



Picture 1 – The structure of complaint causes related to poor-quality medical care for the period of 2006-2008 years

To the first group the complaints related to the human factor – mistakes or non-admission, resulted to poor-quality medical care due to negligent from the side of the medical personnel, lack of attention, rough reference, (picture 2)



Picture 2 - The structure of complaint causes related to the human factor

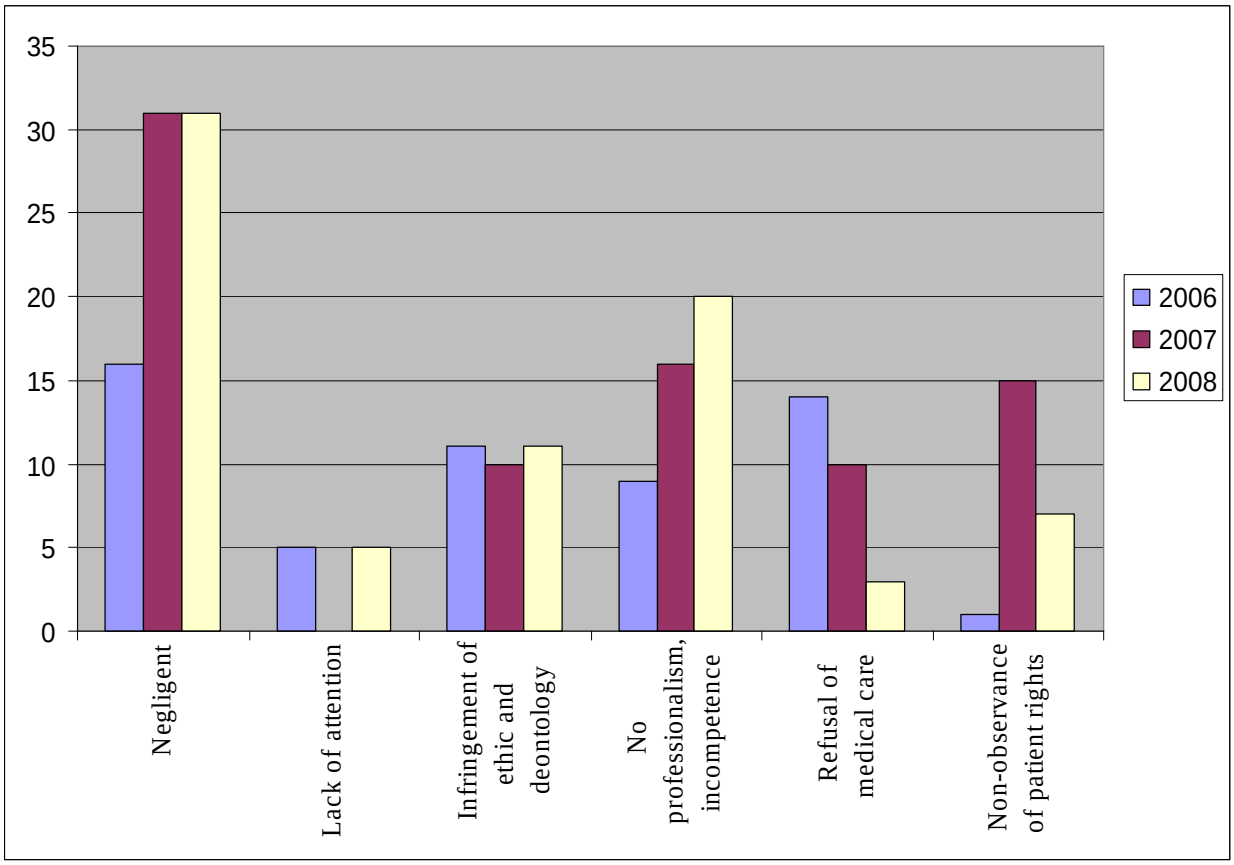
The most percentage of citizens' complaints is related to the negligent of medical personnel to the patients – 39% and just 18% of it are not proven. (Table 2).

Table 2 – Analysis of valid complaints to the poor-quality medical care, related to the medical stuff through the 2006-2008 years.

	Valid	абс.	31	-	10	16	15	6
		%	30,69	-	9,9	15,84	14,85	5,94
2008	Not valid	абс.	10	2	4	1	4	2
		%	9,52	1,9	3,8	0,95	3,8	1,9
	Partially valid	абс.	3	1	1	1	1	-
		%	2,85	0,95	0,95	0,95	0,95	-
	Valid	абс.	31	5	11	20	7	1
		%	29,52	4,76	10,47	19,04	6,66	0,95
year			**Negligent**	**Lack of attention**	**Infringement of ethic and deontology**	**No professionalism, incompetence**	**Infringement of patient rights**	**Refusal of medical care**
2006	Not valid	абс.	1	2	2	1	-	-
		%	1,58	3,17	3,17	1,58	-	-
	Partially valid	абс.	1	-	-	-	-	1
		%	1,58	-	-	-	-	1,58
	Valid	абс.	16	5	11	9	1	13
		%	25,39	7,93	17,46	14,28	1,58	20,63
2007	Not valid	абс.	8	-	-	-	-	3
		%	7,92	-	-	-	-	2,97
	Partially valid	абс.	3	1	5	1	1	1
		%	3,97	0,99	4,95	0,99	0,99	0,99

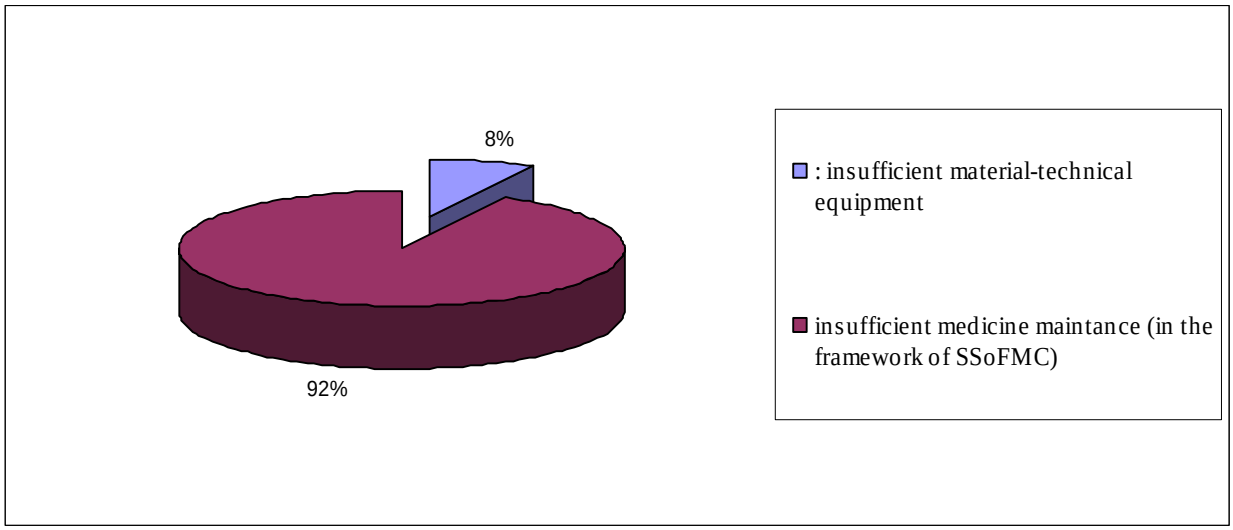
Validation of complaints

Among the causes, related to the human factor 14.8% of is not valid and 7.8% are partially valid. The increase of citizens' complaints to the non professionalism of medical stuff is noticed (picture 3).



Picture 3 – Increase tendency of citizens' complaints through the 2006-2008 years

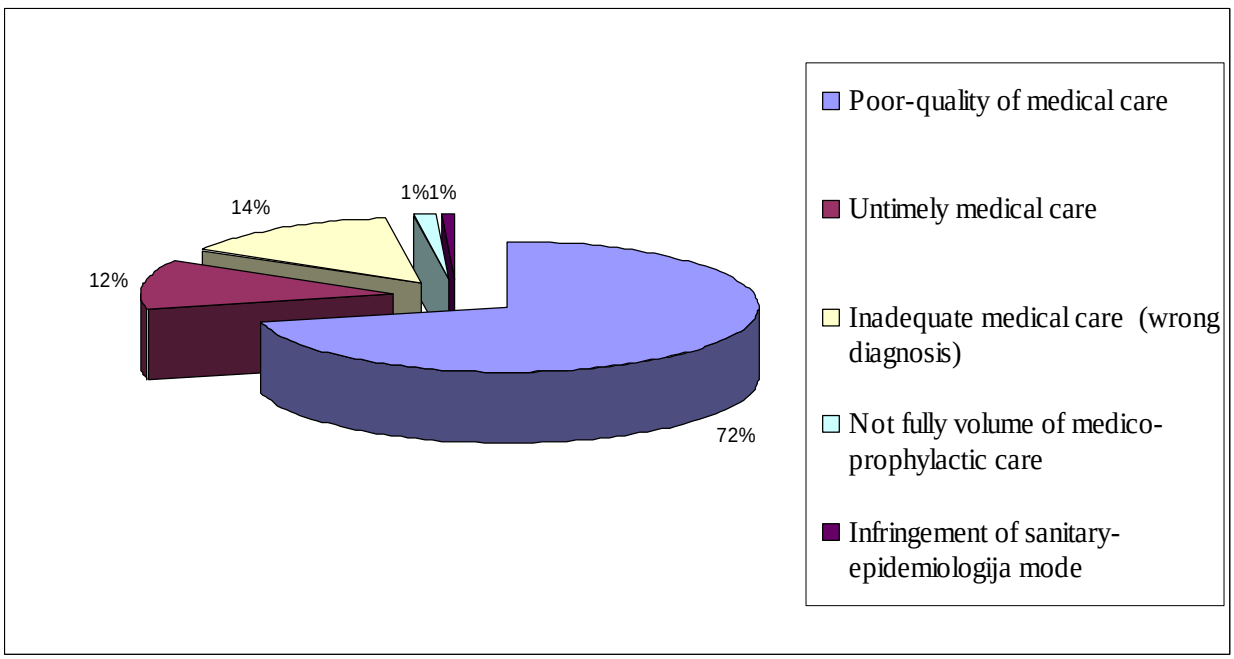
The complaints related to the resource supply: insufficient material-technical equipment and insufficient medicine maintance (in the framework of SSoFMC – State supply of free medical care) are classified as the second group (picture 4).



Picture 4 – Structure of complaints to poor-quality medical care, related to resource supply

Among the all amount of causes from this group the 15% are not valid and related to the insufficient medicine supply (in the frame of SSoFMC). Other causes of this group were proved by experts.

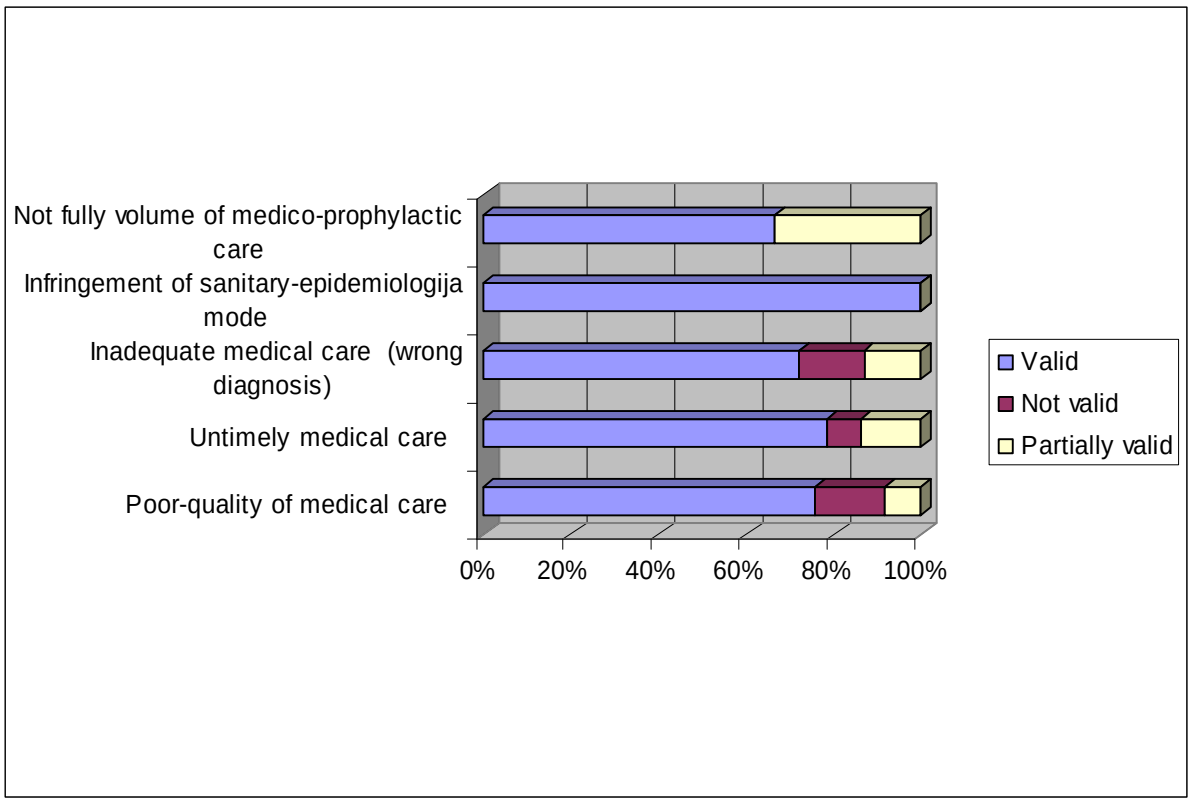
Complaints related to thee medico- prophylactic process: poor-quality and untimely medical care, inadequate of medical care, refusal of medical care, not enough volume of medico-diagnostic events is classified to the third category. (picture 5).



Picture 5 - Structure of complaints to poor-quality medical care, related to medico-diagnostic process

The biggest amount of complaints is the poor-quality medical care – 72% and inadequate medical care (wrong diagnosis and treatment methodology) – 14%.

Through the total amount of complaints according to this group 14.5% are not valid and 9.7% is partially valid (picture 6).



Picture 6 – Complaints causes validity, related to the medico-diagnostic process

Through this cause it is obvious that the big percentage of not valid complaints is the refusal of medical care (18.51% in the structure of this cause) and poor-quality of medical care (15.9%).

Thus, the results of made research give the opportunity to make following conclusions:

1. The main causes of citizens' complaints to the state organization are poor-quality of medical care, manipulations, i.e. low quality of medical process.
2. More than 70% of citizens' complaints valued as not valid.

DYNAMICS OF CHANGE IN UNIT COSTS FOR DIFFERENT TYPES OF VISITS TO PHC ORGANIZATIONS IN ALMATY CITY

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The paper is presenting dynamic evaluation of the changes in unit costs of different types of visits to PHC organizations in Almaty city.

It should be marked, that differentiated registration of various types of visits in OHC organizations is not provided by existing registration system, and therefore tracing of a map of these data has been done out of the primary registration documents.

It was determined, that in average by the polyclinics under the study unit costs per one prophylactic visit in 2003 made up 36,5 tenge; in 2004 they increased by 15,6%; and in 2005 – by another 11,7%.

At that in all joint polyclinics unit costs per prophylactic visit during all researched years were higher, and at child polyclinics – lower than average indicator. The results show that during 2003-2005 resource filling of prophylactic visits was increasing slightly, meaning that technological changes in its contents did not take place.

In study of the dynamics of change in unit costs per one diagnostic visit it was revealed that in average by all PHC objects under the study they made up 103,6 tenge in 2003, in 2004 году they increased by 8,8%, and in 2005 – by 8,5% more. At that in 2003 the highest figures they had in joint polyclinic №1 (121,3 tenge) and joint polyclinic №8 (117,5 tenge), and the least ones – at joint polyclinic №5 (66,5 tenge) and child polyclinic №5 (89,9 tenge). In 2004 revealed tendencies of the year 2003 were kept, and in 2005 – the least unit costs per diagnostic visit were found out again at joint polyclinic №5 and child polyclinic №5.

Transforming of the revealed data of changes in these indicators into grades has shown that in 2004 the biggest positive deviations were observed at joint polyclinic №5 and at child polyclinic №3, and the most negative ones – in joint polyclinic №1, child polyclinics №№5 and 8. In 2005 no significant deviations from the average indicator of the year 2004 were revealed.

It could be supposed that the average growth rates of costs per diagnostic visit by 8,0-9,0% are presenting objective indicator of resource filling of diagnostic visit, and this indicator could be used as an element of its integral evaluation.

It was detected, that average annual growth rates of therapeutic visits are fluctuating between 1,5±1,6. And this indicator could be used in integral evaluation of the quality of

resources provision.

There were also analyzed and evaluated dynamics of change in unit costs per medical-rehabilitative visits. The results of these studies showed that these costs during the whole period of study were of course greater than prophylactic and diagnostic ones, and were greater than of therapeutic visits by 15,0-20,0% .

At that, in 2004 the most positive deviations from the average growth rates of this indicator in grades were revealed at the child polyclinic №5, and the most negative – at the somatic polyclinic №5. In 2005 the average numbers of deviations did not change, except the somatic polyclinic №5, where the greatest growth rate of the explored indicator was revealed.

Thus, it was detected that during the years 2003-2005 resource filling of prophylactic visits was increasing slightly, and increase of costs per diagnostic visit by 8,0-9,0% are presenting the objective indicator of resource filling of diagnostic visit.

ORGANIZATION OF PAID MEDICAL SERVICES IN STATE MEDICAL INSTITUTION

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Recently there is the problem of financial and economic stability achievement in medical organizations. The state medical organizations suffer from deficiency of budgetary funds. To compensate this deficiency, organizations increase the produce of paid services. The finance from paid services should be allocated to maintenance of organizations material base, personnel stimulation, and development of new technologies in their activities.

There is a necessity of reorganization of the activity and structure for official bodies. For the effective organization and coordination of paid activity, the institutionalization of paid services force group is necessary, where everyone is responsible for the certain work. The given service includes experts of various profile, and for a part of experts performance of work will not be basic, and only one of sections, which the given expert (for example, the accountant, supernumerary, economist, lawyer, etc.), supervises that in our opinion is very important, as does not demand creation of new established posts and therefore reduces costs of medical institution.

Organizational - methodical department:

The analysis of a situation in the market of paid medical services for the state medical institution and revealing of basic market tendencies. Reception of the sanction from the higher organization on rendering of paid medical services. Development and the statement «Regulations

on rendering of paid services» medical institution. The coordination of the price-list for services with the higher organization. Preparation of orders under the statement of rules of rendering of paid medical services, under the statement and change of the price-list and its some positions. Development «Regulations», allowing to expect additional wages of employees from rendering paid services, having established its interrelation with the achieved results, and performance of monthly calculations for the account of volumes of paid activity and charge of additional wages. Together with the lawyer development and introduction of various forms of contracts, preparation and study of their conditions for physical and legal persons. Assessment of factors of consumers of paid medical services, forming satisfaction, development of the questionnaire of satisfaction of the patient and its estimation on conformity to put forward requirements and expectations of clients. The further marketing researches of the market of medical services, rendered by medical institution. Calculation of optimum and maximal percent of discounts for medical services for corporate clients with a view of promotion of paid medical services. The information of partners on changes in the price-list. Development of strategy of promotion of new kinds of medical services and products. Gathering and preparation of documents for participation in tenders on rendering of medical services. Development of promotional materials. Study of questions of external and internal advertising. The edition of information materials about activity. Communication with mass media.

Economical department

Data gathering, necessary for calculation of cost of service. Drawing up of accounting. Comparison of settlement cost of service to the price of the given service, working in similar medical institutions. The given analysis is made on the basis of the information, submitted by managers of structural divisions, rendering paid servants and marketing researches of an organizational - methodical department. Creation of the price-list of services. Study of the legislative ground of granting of paid medical services. Drawing up of the estimate on inappropriate activity. The organization personalized the account of expenses on medicines and account materials on rendering of paid medical services. Exhibiting of accounts depending on a source of payment of the rendered services (bookkeeper - cashier is responsible for cash calculation, a financial department of accounts department exposes accounts to the organizations according to contracts).

Paid divisions of medical institution

Treatment all paid patients. The control of payment of the rendered services to stationary and out-patient patients in cash. Drawing up for accounts department of reports on the services paid in cash in a section of each structural division for the further distribution of additional wages to the personnel. Coordination of rendering of medical services to patients, insured on

voluntary medical insurance (VMI). The coordination of volumes of medical aid of the given patients agrees programs and limits of the insurance company. Participation in examinations in case of carrying out of those by the insurance medical organizations. Treatment patients under direct contracts and letters of guarantee of legal persons.

Information service

The information of the population by phone about experts, working in establishment; about conditions of granting of medical services; about established prices for medical services. Record by phone on paid reception to experts of establishment.

Cabinet of medical statistics

Correct input of the information on the rendered paid medical services, including patients under contracts (VMI, direct contracts, letters of guarantee). An assessment and the analysis of satisfaction of patients, preparation of reports for a management.

Adequate use of the given circuit of the organization of paid medical services in official body in modern market conditions will allow to involve additional means in the state system of public health services, to adapt services to requirements of patients, to provide effective use on an end result of available resources.

HEART RATE VARIABILITY AND DIAGNOSIS OF DIABETIC VEGETAL NEUROPATHY

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Key words: heart rate variability, diabetic vegetal neuropathy

This review presents the main definitions of spectroscopic and time parameters of heart rate variability in patients with diabetic vegetal neuropathy; demonstrates the importance of study of time and spectral parameters of heart rate variability for evaluation of the status of vegetative nervous system in this category of patients.

The working group of European Society of Cardiology and North American Society of Cardiostimulation and Electrophysiology has developed the standards od application in clinical practice and cardiological studies of the heart rate variability (HRV), which were published simalteniously in the European Heart Journal (Vol.17,March 1996:354-381) and Circulation (Vol.93,March 1996:1043-1065).

Heart Rate Variability (HRV) — is variation of R-R intervals of consequent cycles of heart beats.

The main indications for study of **HRV** are evaluation of the vegetal regulation background; separation of risk group (stratification of risk) in patients with cardiovascular pathologies (arterial hypertension, IHD, cardiac failure, rythm disturbances), with diabetes; diagnosis of target lesions (vetetative nervous system) and risk of development of cardiovascular complications, including sudden cardiac death; evaluation of intensity of dishormonal changes alongside with diabetes, diseases of thyroid gland, hypophysis, diencephalic syndrome, climax and etc.; choice of medications taking into consideration the vegetal control backround.

The study of time and spectral characteristics of heart rate variability is quite perspective tool in research of vegetative nervous system in patients with diabetes. The method have such an advantages as not invasiveness, safety and possibility for long observation. Therefore, it is necessary to conduct further researches on heart rate variability in patients with diabetic vegetal neuropathy.

THE MAIN FEATURES OF INSURANCE IN THE USA

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The trillion-dollar health care industry-including pharmaceutical companies, hospitals, doctors, medical equipment makers, nursing homes, assisted-living, centers, and insurers-is a fast-growing and dynamic sector of the American economy. Spending for health care is projected to rise to over 3 trillion by 2013, as shown in Figure 1.1. Professional services-the work of physicians and other clinical professionals-and hospital care make up the largest increases. Two factors have caused this growth in health care spending: advances in medical technology and aging American population that is living longer and requiring more health care services.

Continual technological improvements add costs in every area of medicine. For example, an X-ray machine that cost $175000 ten years ago is being replaced by a more powerful CT scan device that costs over 1 million. The latest PET (positron emission tomography) scanner-a

device used to better diagnose cancer-costs 2 million. The average of the population-and the need for health care-are both increasing in the United States. In 1950, the over-sixty-five population totaled 7 percent, or 9 million people. By 200 more, than 34 million Americans, or 12.6 percent of the population, were over sixty-five. The baby boom generation (people born between 1946 and 1964) will reach retirement age between 2010 and by 2030 people over sixty-five likely make 20 percent of the population. The elderly need more health care services than do the young. About 60 percent of all medical dollars are spent on managing chronic diseases, such as diabetes hypertension, osteoporosis, and arthritis, which are more common among those age-sixty-five and older [2].

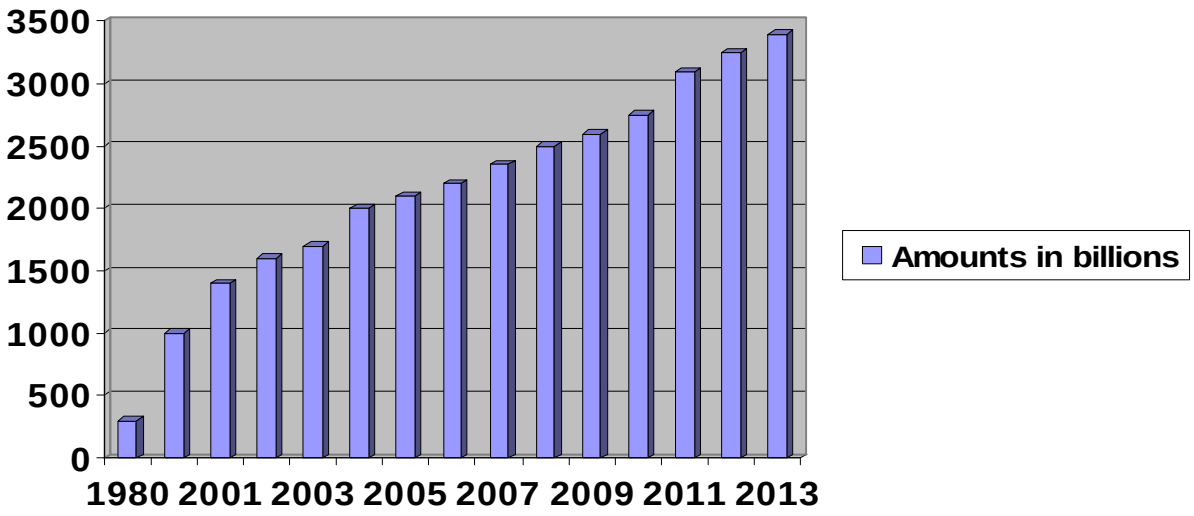

Figure1.1 - Spending for health care

Source: Centers for Medicare & Medicaid Services, Office of the Actuary

Medical insurance was created to pay the costs incurred for the treatment of injuries and illnesses. Policies might pay on a reimbursement, scheduled, or prepaid service basis.

Medical plans are designed to pay for skilled care rendered by licensed medical professionals, to restore health or treat acute or conditions. They are not designed to pay for custodial or non-medical care.

Medical insurance policies are constantly evolving. The following sections discuss some of the basic concepts of medical insurance, and the differences between the various types of policies.

One of the basic differences in medical insurance policies is how they pay for covered services. Most of the policies sold prior to 1993 in New-York State were fee-for-service plans. As the name implies, these policies paid as the insured utilized covered services and incurred

expenses. The more services used, or procedures performed, the more fees were incurred and paid.

With the advent of some changes in state and federal laws, many insurers changed their bases of payment from fee-for-service to prepaid service plans. These types of plans are also known as managed care plans.

The insured prepays a monthly fee (the monthly premium) paid at beginning of each month. This prepayment entitles the insured to covered medical care. No matter how much care is utilized, the monthly fee (premium) is the same.

There is usually a small co-pay required (a flat fee no matter what service are received), but the insured does NOT pay service or procedure.

Some health insurance policies only provide coverage for a narrow range of specified conditions. These are known as limited policies, and a statement that "This Is A Limited Benefit Policy" must be prominently displayed on the first page.

Most policies are comprehensive policies. A comprehensive policy provides broad based coverage for virtually all medical emergencies and conditions. The same amount of coverage is provided whether the medical problem is an illness or injury.

Medical insurance companies control the amounts they have to pay for covered expenses one of two ways.

- Scheduled plans provide a dollar amount, or some point system that leads to a dollar amount, for each covered expense. Schedules are used primarily for surgery.
- Non-scheduled or Usual, Customary, reasonable (UCR) plans do not provide a dollar amount per treatment. Rather, they pay based on a formula that is based on the average charge for service in a given area. The UCR for a given treatment will vary from insurer to insurer.

Different insurers use different databases to create the UCR rates, and some use different geographical parameters, such as per county, per city, or per metro region.

Managed care plans are called managed care plans because the insurer manages or controls most aspects of an insured's care. One of the key elements to managed care is the requirement that insured's are limited to using providers that are part of the managed care network if they want receive care without paying any additional fees beyond the co-pay per visit. Traditional fee-for service plans allow the insured wishes to use. These plans usually require the insured to pay deductible (net cash out of pocket), and co-insurance (a percentage of sharing of loss). There is a price to pay for greater freedom of choice when one needs medical care. The insured has a larger share of the cost of care to pay [3].

Medical plans differ in the amount coverage they providers get paid for the coverage they provide.

Basic Hospital, Basic Medical, Basic Surgical as the names implies, basic plans provide for basic medical needs, with relativity low limits of coverage as compared to comprehensive plans that provide far greater amounts of coverage. These plans are no longer very common. Basic medical plans are effective for minor problems. There are not meant to provide sufficient coverage for major problems. Basic expense plans often written as first dollar coverage, with means they have no required deductible. There are three types of basic coverage.

Basic Hospital Expense provides coverage for room and board (the bed, food, hospital gown) and miscellaneous medical expenses (medically necessary treatments and services).Payments for room and board based on the daily benefit specified in the policy. The policy will pay up to, but no more than, the specified amount. There is usually a limit on the number of days the policy will pay for. Payments for miscellaneous medical expenses are typically calculated based on a multiple of the allowable daily room and board rate. For example, if they daily room and board maximum rate is 300 dollars, the miscellaneous medical expense might be ten times that amount, or up to 3000 dollars during this hospital stay.

Basic Surgical Expense covers the fees charged by the surgeon, assistant surgeon, anesthesiologist, and possibly the operating theater. The policy will have a schedule of benefits payable for a given surgery and a specified valuing method to determine benefits payable for a surgery that might not be on the schedule.

Basic Medical Expense covers physicians other than surgeons anesthesiologist. These benefits will be limited to a maximum dollar amount per doctor visit, and s maximum number doctor visit per year [1].

Also the basic plans have some limiteds for cover:

There are 2 types of limited for cover

A limitation is something that is covered, but not in full.

-Pre-existing conditions

-Maternity

Infertility services

-Treatment for mental illness

An exclusion is something that the policy does not cover at all.

-Self-inflicted injuries

-Injuries sustained in the commission of a crime -

-Illnesses or injuries covered by workers'

-Illnesses or injuries resulting from an act of war,

-Treatment for alcohol or during abuse
-Organ transplants

declared or undeclared or civil insurrection
-Illnesses or injuries while on military duty
-Care provided in government facilities for which no
-Cosmetic surgery, expect for certain reconstructive cosmetic surgery

In conclusion, We would like to note that despite the well-developed system of private and social insurance, medical care not available to everyone, as even a minimum package of insurance is not available on their value and not cover sometimes necessary medical assistance to U.S. citizens, as President of the United States Barack Obama, to date, the U.S. health care system needs a thorough reform.

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THE CONTEMPORARY TENDENCIES IN REPRODUCTIVE HEALTH BEHAVIOR OF WOMEN IN THE KYRGYZSTAN.

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Key words: reproductive behavior, childbearing age, birth rate, abortions, methods of contraception.

Aim of the study. To assess sexual and reproductive health behavior of the women in childbearing age, their main characterictics and tendencies of change, and also the development

of family planning strategy under the modern conditions.

Material and methods. The survey was conducted among 680 sexually active women at the age of 15-44 yaer old, with the use of a specially developed questionnair.

Results ans discussion. The study revealed low bith rate, the average age of the first child-bearing was 22,3 years old, and the high level of abortions, including the recurring abortions. In the reproductive plans of female citizens – unwillingness to have more children or to postpone their birth for the period more than 3 years. Women are relatively well-informed about methods of contraception and are using them, mainly intrauterine and barrier methods.

Conclusions. Thus, the current objectives of the health care organizations, rendering reproductive services, are to activate programs on family planning and to increase the quality of services in this area, as a main measure to improve health of mother and child.