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ADDRESSING INFORMAL PAYMENTS IN KYRGYZ HOSPITALS: A PRELIMINARY ASSESSMENT

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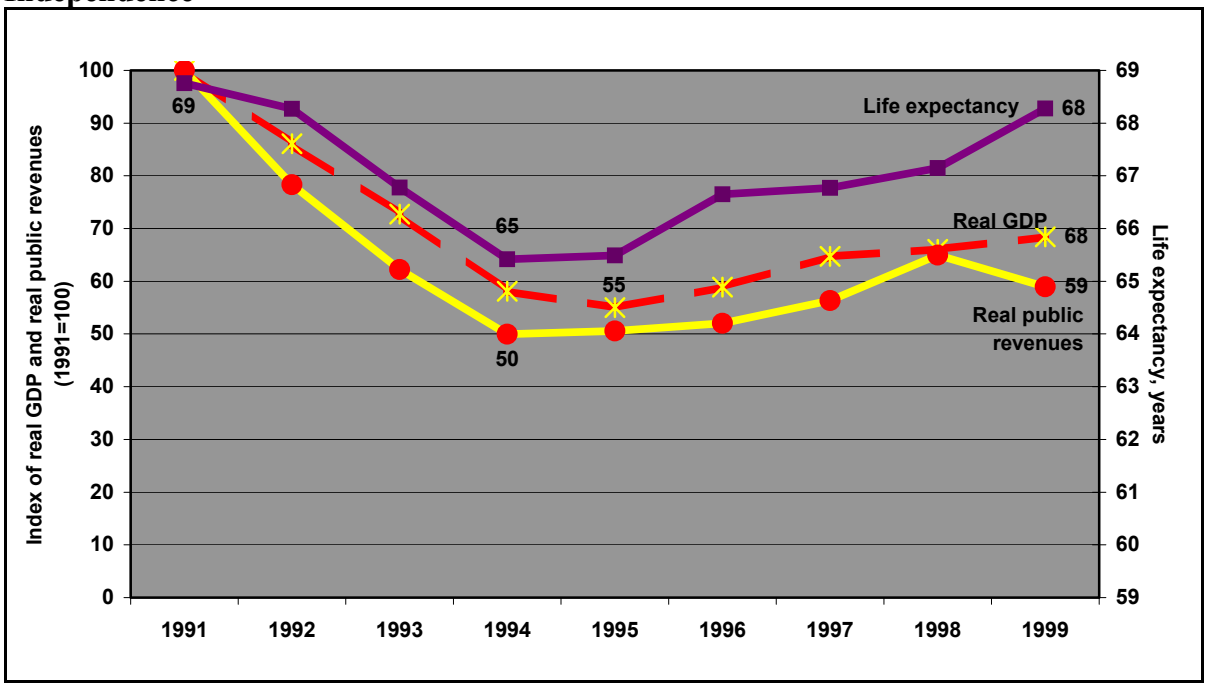
Background

The context of transition

The Republic of Kyrgyzstan is a Central Asian country that became independent in 1991 following the collapse of the Soviet Union. The World Bank classifies Kyrgyzstan as a low income country with a per capita GNP of $300 in 1999 ($2,203 at Purchasing Power Parity). Household survey data (NSC 2001a) indicate that 55% of the population lived below the poverty line in 1999.

The Kyrgyz health system underwent severe financial stress during the economic transition following independence. There was a decline in the main health indicators (e.g. life expectancy) until 1994-95, and then recovery since that time. The trend in broad health indicators mirrors that of the real levels of GDP and public sector (mainly tax) revenues (Figure 1). Despite the recovery in the latter half of the decade, real GDP and public revenues were still far below their independence levels. This situation reduced substantially the ability of the government to fund its commitments in the health system.

Figure 1. Trends in Real GDP, Real Public Revenues, and Life Expectancy since Independence



Sources: Izvorski and Gürgen (1999) and Abdymomunov (2000) for real GDP growth data. NSC (2001a) for data on public revenues and the level of GDP. WHO (2001) for life expectancy data. Public revenue data exclude grants and off-budget (payroll tax) funds.

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Inherited arrangements for hospital financing and health system organization

The inherited health system was characterized by excess capacity, particularly at the hospital level. Several factors contributed to this. First, the method for allocating resources to providers, driven by input norms (e.g. number of beds), rewarded expansions in physical capacity. The consequences of this financial incentive were compounded by the organizational structure of the health system. Each level of government had its own delivery system that integrated the pooling, purchasing, and service provision functions within the same organizational entity (e.g. the oblast health department, or OHD). Responsibilities for population coverage were duplicated between different government levels, particularly in the capital cities of each oblast,[1] and in Bishkek, the national capital. This vertical integration of the health systems of different levels of government, combined with overlapping geographic population coverage, resulted in duplication of service delivery responsibilities. With this organizational structure, there was no incentive to plan health services on a population basis, and no incentive for different levels of government to coordinate service delivery. Finally, these organizational and financial incentives reinforced the way that health professionals were trained in the Soviet system. Clinical protocols and norms encouraged, and even required, an emphasis on specialized hospital care, and the principal role of primary care providers was to "dispatch" patients to specialty providers and facilities (Kutzin *et al*. 2001).

Excess capacity was the main reflection of the inefficiency of the system driven by these financial incentives and clinical practice patterns. For example, Kyrgyzstan had about 15% more hospital beds and nearly twice as many hospitals per capita as the average for EU countries in 1998 (WHO 2001), despite having a far lower income level. With the transition to a market economy (changing the relative price of inputs in the system) and the fall in real public revenues reducing government's capacity to finance public services, the weight of this infrastructure became increasingly difficult to sustain. Together, expenditures on personnel and utilities (mainly heating and electricity) absorbed about 70% of public budget health spending in 1999 (Government Treasury data). In fact, this is an underestimate of the real costs of these services because the health sector has benefited from implicit subsidies from public utility companies in the form of unpaid bills (World Bank 2001).

Informal payments by patients for hospital care

Although user fees were legalized shortly after independence, most observers believe that illegal, informal payments made by patients have long been of far greater magnitude. Lewis (2001 forthcoming) defines informal payments as

> "payments to individual and institutional providers in kind or in cash that are outside official payment channels or are purchases meant to be covered by the health care system. This encompasses 'envelope' payments to physicians and 'contributions' to hospitals as well as the value of medical supplies purchased by patients and drugs obtained from private pharmacies but intended to be part of government-financed health care services."

The limited available evidence suggests that both kinds of informal payments (i.e. payments to staff and the purchase of inputs that are meant to be provided by the system) occur in Kyrgyz hospitals. Results from a 1994 household survey suggest that 86% of inpatients

[1] In the Kyrgyz governmental structure, an "oblast" is equivalent to a province or state, and a "rayon" is equivalent to a district.

paid something toward the cost of their care. For an average inpatient stay, about 60% of payments was for drugs, 18% was for payments to staff, 14% was for surgical supplies, just over 3% was for official fees, and the rest was spent on various other items (Abel-Smith and Falkingham 1995). A 1997 survey in two oblasts (Blomquist 1997)found that most inpatients had provided medical and non-medical inputs, and a 2001 national household survey suggests that the frequency of this was even greater (see Table 1). The latter survey also showed that nearly all inpatients paid something towards their hospitalization. (Falkingham 2001; NSC 2001b)

Table 1. Provision of inputs by family members for inpatients

	1997, two oblasts	2000-01, nationwide
Medicines	65%	81%
Food	84%	95%
Linen	55%	74%

Sources: Blomquist 1997; Falkingham 2001.

Finally, there is reason to believe that the demand for payments by health workers has grown. According to official government statistics, wages in the health sector have always been below average for the country and have declined in relative terms from 92% of the average wage in 1994 to 52% by 1999 (NSC 2001a). Together with the survey evidence reported above, it is clear that informal payments were occurring in Kyrgyz hospitals and that increasingly, access to effective inpatient care, including drugs, medical and non-medical supplies, and the time of providers, depended on the ability of the patient and his/her family to pay for these.

Informal payments were the tangible symptom of a system characterized by excess physical and human resource capacity in a context of shrinking public resource availability, low wages, and rising prices. Given this, the only realistic way to address informal payments was as part of a package of measures aimed at the causes of inefficiency while injecting a small amount of additional funds into the system.

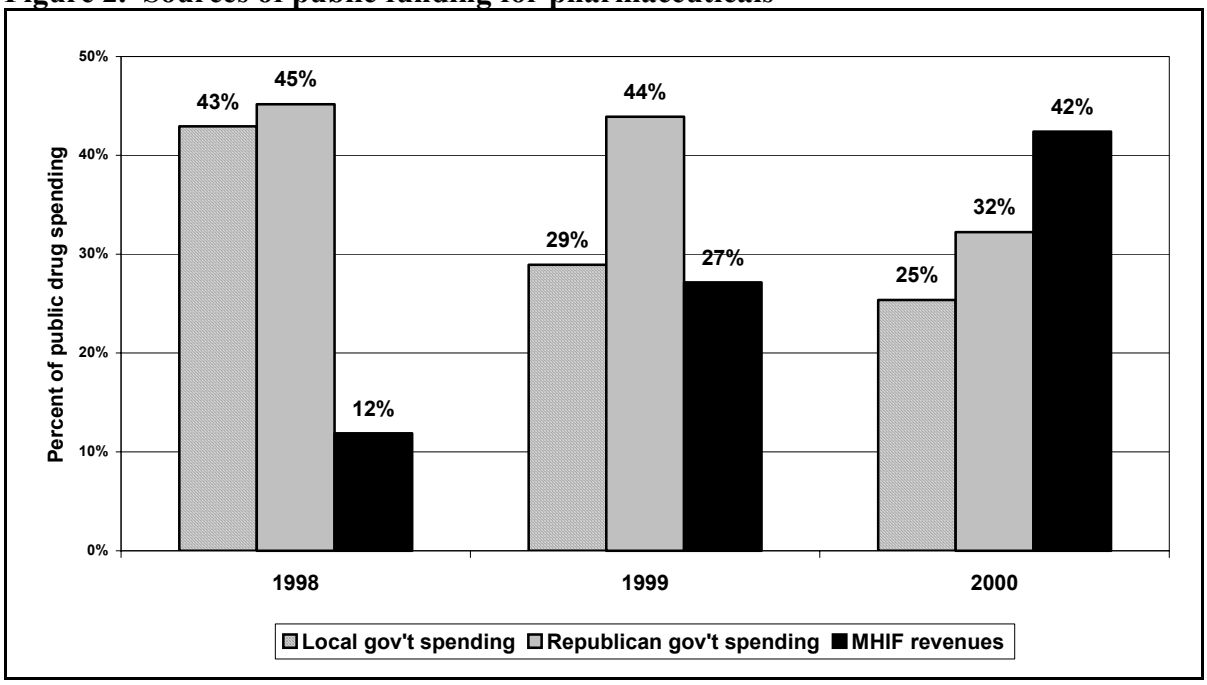
Hospital payment in the first phase of reforms: 1997-2000

In 1997, the government introduced the Mandatory Health Insurance Fund (MHIF) as an independent agency. Initially, the population groups covered by the MHIF were employees for whom employers (including the public sector from 1998 onwards) made a 2% payroll contribution as part of their overall payroll tax obligations, as well as pensioners and the registered unemployed, whose coverage was funded out of the pension and unemployment insurance funds, respectively. A substantial increment to population coverage occurred in 2000 with the addition of all children under 16 (and full-time students under 18), as well as persons receiving social benefits from the government. The coverage of these groups was funded by a direct transfer from the Republican budget to the MHIF. About 30% of the population was covered by the MHIF in 1999, but the inclusion of children brought this to nearly 70% in 2000 (Kutzin *et al*. 2001).

The level of funding provided by the MHIF was very small when compared to that from the budget: less than 5% of pooled health sector funding in 1998 and 8.5% in 1999. Because MHIF payments were limited to general hospitals and primary care, a more relevant comparison is with MOH budget spending on general hospitals. In 1999, the MHIF share was just over 12% (Kutzin *et al*. 2001). Despite this low level of funding, MHIF payments may well have mitigated the rise in informal payments. The management of the MHIF took

a strategic decision to limit the use of its funds by hospitals to two items: staff bonuses (30%) and drugs (70%). The additional resources provided for these could have reduced the demand for private payments from health workers and should certainly have reduced the need for insured persons to buy their drugs. Indeed, the impact of the MHIF on drug funding was substantial even when measured at the overall level of the health system. By 2000, the MHIF was funding over 40% of recorded drug costs in the health system, and so the impact in those hospitals with which it contracted was considerably greater (Figure 2).

Figure 2. Sources of public funding for pharmaceuticals



Source: MHIF data.

The MHIF introduced the concept of "active purchasing" and a purchaser-provider split into the Kyrgyz health system. Contracted hospitals were paid according to a case-based system modeled on the US DRG system. Importantly, the MHIF did not create a separate, parallel health system; instead, its case payments were incremental revenues to hospitals that continued to receive a budget allocation according to the old methods. The MHIF and MOH worked together closely, an arrangement that was formalized in 1999 when the MHIF was brought under the explicit policy direction of the MOH, while maintaining its separate source of funds. One example of their coordination was that any hospital contracted with the MHIF had to use a new Clinical Information Form (CIF) and report data on all patients using the new forms. The data from these forms was used for the statistical purposes of the MOH as well as for the payment and utilization review functions of the MHIF (Kutzin *et al*. 2001).

The payment systems of the MHIF injected both additional resources and a new way of doing business into the health sector. Although there is no direct evidence of the impact on informal payments in hospitals, the MHIF's purchasing strategy addressed two of the causes of these payments: low salaries and limited availability of drugs. However, the underlying structural inefficiencies of the system were not addressed in this first phase of health reforms.

2001: Introduction of the "Single Payer" reform

In 2001, the MOH introduced a comprehensive package of measures under the rubric of the "Single Payer" reform. These were introduced in two oblasts in 2001 with a plan to extend the reform nationwide by 2003. Relevant features of the Single Payer are:

- pooling of all local budget funds for health in the territorial department of the MHIF (TDMHIF);
- payment of providers from these resources according to the systems of the MHIF, delinking the amount of budget revenues received by a facility from the number of beds that it has; and
- establishment of an explicit, formal and differentiated co-payment for inpatient care meant to eliminate all informal payments at that level.

The critical aspect of the Single Payer (and the reason for this title) is the creation of a single pool of funds for health care at the oblast level, which effectively eliminates the fragmentation and duplication of the former system. This was made possible by a government decision in early 2000 to eliminate the OHDs as part of an overall streamlining of the health sector. The MOH responded to this by proposing that all local government budget health care funds be administered by the oblast TDMHIF rather than being retained and distributed by the oblast administrations. This proposal was accepted by the government. Shortly thereafter, government decrees were approved for the TDMHIFs in two oblasts (Chui and Issyk-Kul) to apply the payment methods of the MHIF to budget funds for primary and inpatient care. The details of the administrative arrangements were developed during the rest of 2000, and the policy was implemented in January 2001.

Hospital copayment under the Single Payer

Within the context of the Single Payer, the objectives of the copayment policy were multifold:

- to formalize payments for inpatient care and make the contribution and collection process transparent;
- to find an additional source of funding for the health system; and
- to promote access to needed care for defined population groups via exemption mechanisms.

Although the Single Payer was introduced in January, it took somewhat longer to work out the details of the copayment policy, and it was not implemented until March 2001. The inpatient copayment is linked to the inpatient payment system of the MHIF and includes three main levels, paid as a flat fee per admission:

- 1,140 soms[2] for uninsured persons
- 570 soms for insured persons
- 190 soms for partially exempt persons (and 0 for those few groups that are fully exempt)

The copayment levels are inversely related to hospital payment rates from the purchaser. Local budget funds pooled in the TDMHIF are used to pay a common "base rate" (prior to the case category adjustment) for all patients. An additional amount of budget funds is set

[2] Approximately 49 soms = US$1.00 in May 2001.

aside to pay a higher base rate for partially and fully exempt persons. For insured persons, the standard uninsured base rate is paid from budget funds, and an additional base rate is paid from the MHIF national pool of funds. As noted earlier, there is not a separate "insurance system" for MHIF beneficiaries. Instead, MHIF coverage entitles the beneficiary to a lower copayment, in much the same way as coverage by a *mutuelle* in France or a "Medi-gap" policy in the US. With the payment by the MHIF (national) still supplementary to that paid from budget sources, there is no fragmentation of the population (and the system) into separate pools. Most importantly, the TDMHIF is organizationally distinct from service providers (i.e. it is not a part of the oblast or rayon government), and this combined with the new payment methods means that a true purchaser-provider split exists, thereby removing one important structural barrier to system rationalization.

Effects of the policy on informal payments: some early findings

Because the policy was only implemented in March 2001, any assessment of its effects should only be considered preliminary. However, some analyses that have already been completed give a sense of how the policy has been implemented to date as well as its effects in terms of the utilization of services and acceptability to the population. First, however, we present information from a recently available household survey that provides evidence on the frequency and extent of private payments in hospitals for the year just prior to the implementation of the copayment policy. It is particularly useful to assess the policy in the context of these findings.

Summary of household survey findings

The national survey of 3,000 households comprising about 12,900 individuals was implemented in February-March 2001 and provides information on hospitalizations for the 12 months prior to the conduct of the survey. Preliminary analyses of the survey (Falkingham 2001; NSC 2001b) suggest that nearly all inpatients paid something during their stay (Table 2). The expenditures on food, medicines, and other supplies can be considered "informal" because these inputs are meant to be provided by the hospital. Most people (87%) paying "hospital" and laboratory charges did *not* get a receipt, so it is not clear whether such payments (for which various official charges do exist) should be considered formal or informal. In general, payments to staff were reported to have occurred relatively infrequently, although virtually all persons who had an operation reported paying something to the surgeon.

Table 2. Payments for inputs and services during hospitalization

		Amount paid (soms)	
Item	**Percent that paid**	**Mean**	**Median**
Food	93%	372	300
Medicines	83%	572	300
Other supplies	67%	142	90
Hospital charges	48%	156	30
Laboratory tests	55%	64	20

Source: Falkingham 2001.

In total, the average level of payment for a hospitalization is summarized in Table 3. These figures suggest that if the copayment has been implemented as planned, both insured and

uninsured persons would pay less than the mean amounts paid prior to the policy.[3] The insured would also pay less than the median, but the uninsured would not. In relative terms, the patients in Chui hospitals would be better off under the copayment than those in Issyk-Kul.

Table 3. Average amount paid per hospitalization

	Mean amount paid (soms)	Median amount paid (soms)
Nationwide	1270	720
Chui oblast	1416	900
Issyk-Kul oblast	1385	630

Source: Falkingham 2001.

Is the copayment policy working? Do the people accept it?

A preliminary "rapid appraisal" study using techniques of Participatory Rural Appraisal was implemented in May 2001 to provide rapid feedback to the MOH on the copayment policy (Schüth 2001). This study utilized 9 focus group interviews with 63 participants in Chui and Issyk-Kul, 52 of whom had received hospital treatment under the copayment policy. The most important findings are described below.

First, the policy appears to be working: most patients made the official copayment without paying other charges. 45 of 52 patients interviewed made no extra payments for drugs, laboratory, and x-ray, and only 1 patient reported making an "informal" payment to a doctor. However, most patients had family members bring food from home.

Second, acceptance of the policy is mixed, with most non-maternity patients supporting the policy but with near universal opposition to the copayment for deliveries. The main reasons given for the positive view of the policy with regard to non-maternity care were that: (a) many patients (especially the insured) are paying less than what had been paid previously for the same treatment, especially for surgery; (b) patients are seeing drugs and supplies available in the hospital rather having to purchase these themselves in pharmacies; and (c) patients see the sharing of the burden between the state and the individual as fair. While the view was generally positive, concerns about the policy were also raised. The copayment levels may pose a significant financial barrier to access, particularly for uninsured persons who do not qualify for exemption.

There was a very strong negative view of the copayment policy for deliveries, mainly because the copayment level was viewed as much too high. Most respondents said that the copayment was several times higher than what women had been paying informally). Concerns were raised that the policy would lead some women to deliver at home to avoid these costs.[4] The high copayment level for deliveries is a consequence of the nature of insurance coverage under the MHIF. As noted earlier, the main population groups covered by the MHIF are children, employed persons for whom employers have made a contribution, and pensioners. Because of this, women of reproductive age are least likely to be covered. In February 2001, for example, there were 36,924 cases in hospitals contracted

[3] Because the survey has a 12-month recall period for hospitalization, a proper comparison with the copayment levels would adjust upward the average payments from the survey slightly to incorporate inflation during 2000. Thus, there is a slight bias in the comparison and indicates that in real terms, the median and mean payments prior to the copayment were slightly higher than the amounts reported in Table 3.

[4] So far, however, utilization data do not support this concern. Despite an overall decline in utilization in 2001 relative to 2000 for the months of March – July, the number of maternity cases has actually increased.

by the MHIF nationwide. 66% of these were for insured persons. Of the 2,487 maternity cases in that month, however, only 19% were for insured persons (MHIF data). Hence, most delivering mothers are uninsured and face the highest level of copayment.

Utilization impact

The Single Payer established conflicting incentives for the level of inpatient utilization. The shift to an entirely case-based payment system created an incentive for hospitals to increase the volume of admissions. The copayment erected a formal barrier to utilization on the demand side, although it was impossible to know if this implied an increase or a decrease in the real price facing prospective hospital users. The MOH/MHIF were very concerned that the net effect of these changes would be an increase in the volume of admissions that would create financial problems for the Single Payer.

Evidence to date suggests that the feared increase in admissions may not occur. Overall, the number of admissions was about 23% less in 2001 than in 2000 for the March – July period (see Table 4). Indeed, there has been a decline in utilization which may be attributable to the copayment. The magnitude of this decline was larger in Chui than in Issyk-Kul, which is surprising given that the Chui population is richer, on average, than that of Issyk-Kul, and also given the findings from the household survey on the average amount paid in the hospitals of each oblast in the year prior to the copayment policy (Table 3). Also of interest is that the decline in utilization appears to concentrated in rayon hospitals; indeed, the utilization of oblast hospital appears to have increased.[5]

Table 4. Change in level of hospitalization from 2000 to 2001, March – July

	% change
Chui Oblast	
Oblast hospital	2,9%
Rayon, municipal and enterprise hospitals	-36,6%
All Chui hospitals	*-31,5%*
Issyk-Kul Oblast	
Oblast hospital	39,0%
Rayon and municipal hospitals	-21,7%
All Issyk-Kul hospitals	*-3,6%*
Both Oblasts combined	
Oblast hospitals	22,3%
Rayon, municipal and enterprise hospitals	-32,7%
All hospitals	*-22,8%*

Source: MHIF data.

While the lack of increase in utilization may be re-assuring in terms of financial sustainability, the decline in utilization suggests that some people who need care are not getting it because of financial barriers resulting from the copayment. While it is possible

[5] Some of the apparent increase in the utilization of oblast hospitals may be an artifact of an organizational reform implemented during 2000 that merged, from an administrative and legal perspective, several specialist oblast hospitals together into a single entity. To the extent that admissions from those specialized hospitals are not included in the 2000 data but are included in the 2001 data, the percent change in admissions in oblast hospitals is overstated.

that the copayment policy deterred "unnecessary" hospitalization, international experience suggests that this is unlikely, especially for inpatient care for which utilization is largely provider-driven (Kutzin 1998).

It is difficult to determine in the Kyrgyz context at the present time is whether the implementation of the copayment policy effectively raised or lowered the price of hospitalization facing patients. This is likely to vary by individual patient characteristics, such as their insurance and exemption status, the nature of their hospitalization (e.g. surgical vs. non-surgical), and their income. The averages presented in Table 3 are not adequate to determine how the copayment affects the behavior of *individual* prospective patients. Even if the copayment price is the same as the "informal price", the copayment should pose less of a barrier because of the greater uncertainty likely to be associated with informal payments. Despite these points and the data from Table 3 suggesting that the copayment probably lowered the price in most cases (especially for insured persons), the downward trend in utilization (Table 4) is cause for concern, especially for rural populations that are more likely to make use of rayon hospitals.

Conclusions and next steps for policy and research

The limited available evidence to date suggests a mixed picture with regard to the copayment policy. The qualitative research found a generally favorable impression by the population (excluding maternity care), and a comparison of the copayment levels with the survey data on private payments in hospitals suggests that prices are now lower than previously. The main negative findings are the unpopularity of the copayment for maternity care and the decline in hospital utilization, especially at rayon level.

Politically, the biggest concern associated with the policy is maternity care: how can the copayment for deliveries be lowered? The MOH is seeking a solution to this but needs to find a way to take a greater share of the financial burden away from patients. One possible solution would be to cover all pregnant women by the MHIF, thus entitling them to a lower copayment. This coverage could be financed by a direct transfer from the Republican budget, in much the same way as children's health insurance. While it is unlikely that coverage of pregnant women would create a moral hazard problem, it is possible that there would be an increase in maternity admissions, if women shift from home to hospital delivery. While more costly to the system, such a shift would be desirable in terms of quality of care.

Overall, the success of the Single Payer depends on the extent to which it induces a reduction in the fixed costs of the health system through downsizing of the physical infrastructure as well as of staff, without a concomitant reduction in health system funding. It is only in this way that resources can be freed for reallocation to variable cost items and increased salaries. In turn, such reallocation can enable the copayment policy to succeed in the longer term by reducing pressures for supplementary private payments.

The findings presented here give a picture of the effects of hospital copayment within the broader context of the Single Payer reform during the first few months of implementation. Ongoing research will attempt to determine more precisely the effectiveness of the policy, whether it entails an increase or decrease in the price facing patients (which will provide indirect evidence of its impact on access to care), and the extent to which the effects of the policy vary across regions. Additional qualitative research will also be undertaken to get an idea of how to improve the policy to promote better access for particularly "at-risk" persons,

such as the poor, persons outside the cash economy, and persons living in remote areas. This research should lead to concrete policy recommendations that the government can consider as the Single Payer and copayment policies are “rolled out” to the rest of the country.

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