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Evaluating the Manas Health Sector Reform (1996-2005): Focus on Health Financing

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1 Executive summary

The purpose of this paper is to contribute to the discourse on health care financing after a decade of intensive reform in this area. We aim to contribute a comprehensive evaluation of the implemented reforms to date, to discuss lessons leant and to highlight the policy implications of our findings for Manas-II.

Kyrgyzstan inherited a health financing system similar to that of other countries in Former Soviet Union and Central-Eastern Europe. The early transition period, with its economic decline and severe fiscal contraction, exposed similar problems in the Kyrgyz health system as in other transition economies of the FSU & CEE region. These problems included erosion in previously high levels of financial protection, inequitable distribution of public resources disproportionately favoring tertiary facilities in the capital city, inefficiently large service delivery sector, and quality problems.

In response to these challenges, Kyrgyzstan introduced a systemic reform changing several key aspects of the health system. Reform of health care financing was one component of a broader systemic reform. The introduced health financing model has become widely known locally and internationally as the “Single Payer System”. This name captures the key idea of the Kyrgyz model which is the creation of single payer oblast level purchasing pools under the Mandatory Health Insurance Fund. In each oblast, there is one purchaser of health services, for those services that are part of the State Guaranteed Benefit Package (SGBP). These purchasing pools are called Territorial Departments of the Mandatory Health Insurance Fund (TDMHIF). All oblast and sub-oblast tax revenues are transferred to and pooled in these oblast purchasing pools.

Providers covering services in the SGBP receive payment from the MHIF and its territorial departments on the basis of their outputs. In primary care, Family Group Practices (FGP) are paid based on the number of people enrolled with them (capitation payment), and hospitals in the single payer system are paid based on the number of admitted patients with adjustments for severity of illness (case-based payment). These new methods of paying public providers mean a complete break from the previous historical line-item payment method which contributed to inefficiencies and quality problems.

These changes in health care financing led to significant improvements in the performance of the health system and in the health care services people receive. We review six dimensions of health system performance in this paper that are directly related to health care financing. Since several papers documents achievements in the early reform period, we focus our attention to the recent period and analyze data for the years 2000-2003. We find that Kyrgyz health financing reforms have achieved improved equity of access to health care services, greater transparency, improved efficiency and quality of service provision, and remarkable administrative efficiency. At the same time, remaining challenges include improvement in financial/risk protection by reducing the burden of direct health care payments on households which in turn requires providing sufficient resources from public funding for the health sector. (

Table 1)

Table 1. Summary of performance assessment

	Significant progress	Continued challenge
1. Generating sufficient resources to meet health system objectives		ü
2. Incentives for efficiency and quality	ü	
3. Administrative efficiency	ü	
4. Transparency	ü	
5. Equity in access	ü	
6. Providing financial/risk protection		ü

Generating sufficient resources to meet health system objectives

Public expenditures in the Kyrgyz Republic were critically low over the time-period of 2000 and 2003. Budget allocations as well as budget execution were lower than expected and needed for smooth functioning of the health system. The level and predictability of public funding began to improve in 2003 and this improvement was sustained throughout 2004. Further improvement in the flow of public funds is a precondition for improvement of financial/risk protection and more visible reform benefits for the population.

Private out-of-pocket expenditures have been rising significantly and continue to place a high burden on households. Household expenditures on pharmaceuticals are fueling the growth of health expenditures and this area merits policy attention. Households' financial burden has been on the rise paralleling the decline in public funding. Due to the unpredictability of need for medical services, out-of-pocket payments are one of the least efficient mechanisms to pay for health care services and leave the population without financial protection against the risk of a potentially costly illness episode. The scope for further reform to mitigate this burden is limited (e.g. through exemption schemes, etc.) and increased public funding is essential to achieve improvement in financial/risk protection.

Incentives for efficiency and quality

There are documented improvements in the efficiency and quality of the Kyrgyz health system. These achievements are due in large part to the adoption of "strategic purchasing" using output based payment mechanisms, sophisticated incentives for referrals and exemptions, the Additional Drug Package and regular monitoring of quality. All these tools have provided explicit incentives for efficient and high quality provision of health care. In Kyrgyzstan, having a para-statal agency in charge of purchasing has proven to be critical to implementing a strategic purchasing function. If the MHIF had been set up within the core public sector, it would not be able to purchase services "strategically" because of the administrative constraints of the Kyrgyz public finance system.

Administrative costs

The MHIF, including its Territorial Departments, are constrained by law to ensure that their administrative expenses do not exceed 5% of the payroll tax revenue it receives from the Social Fund. Since the MHIF is also responsible for managing (pooling, purchasing) sub-national budget funds, the actual administrative expenses in their total volume of financing is significantly lower. This level administrative expenditure is significantly lower than we find in the social insurance based health systems of Europe signaling good administrative efficiency of the MHIF.

Transparency

The Single Payer system has improved the transparency of the health system for the population by creating a clear system of benefits and entitlements through the SGBP and the co-payment policy. Previously, the lack of clarity about entitlements coupled with great pressure on providers to replace markedly declined public funding led to a wide-spread system of informal payments, in particular for hospital care. A key objective of the health financing reforms was to begin to make the health system more transparent by clarifying entitlements to benefits and responsibilities. This study shows that informal payment reduced by 2% in the early reform oblasts of Issyk-kul, Chui, Naryn and Talas where the reforms have had a longer period to take hold. In contrast, informal payment increased by 73% in the late reform oblasts of Osh, Jalal-Abad, and Batken, and it grew by 24% in Bishkek during the same time-period. The positive trends in the decline of informal payments in early reform oblasts suggest that consistent and full implementation of the single-payer reforms would lead to similar benefits in other parts of the country over time. Further reduction in informal payment is only possible with generating a stable and growing base of public resources for the health sector.

Equity in access to services

The distribution of utilization of health care services across socio-economic groups has become more equal in 2003 than it was in 2000. This is the case for both outpatient and inpatient care. Utilization of outpatient care (primary care and specialist care) has increased among the poorer half of the population while it declined among the richer half. This means that the poor are able to capture a greater share of public resources than before. Overall, health reforms appear to play an equalizing role on utilization across the country and across socio-economic status.

Financial protection

Although inequalities in utilization have become less pronounced over the past few years, seeking health care services continues to place a great burden on household resources through out-of-pocket payments. Although the payments are lower in absolute terms for the poor than for the rich, they demand a greater share of household resources measured in terms of per capita consumption. The share of out-of-pocket payments in household resources grew significantly among the poorest quintile to 7% by 2003. The 2nd, 3rd, and 4th quintiles also devoted a greater share of household resources to health expenditures in 2003 than in 2000. The richest quintile experienced a slight reduction. This is mostly driven the declining utilization of health care among the rich.

Lessons learnt

The Kyrgyz health financing reforms have contributed to greater efficiency, better quality, improved transparency and more equal access to health care services. These are great achievements indicating that the health financing system and its components are working to the intended direction. This is largely due to the sophisticated pooling and purchasing arrangements with a wide-range of incentives aligned to promote efficiency, quality and equity.

The key lessons learnt in the implementation of these reforms are as follows:

- The successes of the Kyrgyz health reform are in part due to focusing on a comprehensive approach rather than on isolated instruments.

- Complex reforms require careful sequencing of various reform steps.

- Funding for the health system has been critically low and unpredictable over the time-period of reform implementation. This has led to several problems for the operation and credibility of the health system and also undermined the ability of health financing reforms to mitigate the financial burden associated with seeking care, particularly for the poor.

- The slow pace of reforms in the overall public finance system created a challenging environment for the health sector to operate in and limits its ability to achieve efficiency, quality and equity gains.

- Progress on efficiency and quality would have been much more difficult had the MHIF not been formed as a para-statal agency in charge of purchasing.

Policy recommendations for Manas-II

Based on analysis in this paper, the following policy recommendations emerge for health care financing.

- The Kyrgyz health financing system is a sophisticated arrangement for pooling of funds and purchasing health care services in a strategic manner. As demonstrated in this paper, this system has contributed to progress in several key reform objectives. The single-payer system and the co-payment policy should continue to form the backbone of the Kyrgyz health system. Although some objectives such as financial protection have not yet improved, it is important to recognize that this would have been an impossible task under declining and unpredictable flow of funds during the period of reform implementation for any health financing system. Thus, our first policy recommendation is not to roll back the single payer reform and the co-payment policy. Rolling back the implemented health financing reforms would in fact not improve financial protection as informal payments would return, and would lead to loss of transparency and decline in efficiency and quality.

- A critical task for the coming time-period is to focus on improving financial/risk protection by reducing households' financial burden at the time of seeking care. In particular, increased public funding would allow reducing co-payment levels across the board and would go a long way in reducing the financial burden of illness for the poor. Further, revision of pharmaceutical pricing and rational drug prescription practices would also go help ease the financial burden of health care for households.

- A further challenge is the harmonization of the single payer system with the fiscally decentralized public finance system. Having reviewed several options proposed earlier in 2005, we conclude that decentralization of health financing the low administrative levels is likely to undermine the systems' ability to raise resources, it would destroy the current pooling and purchasing arrangements with a resultant negative impact on efficiency and quality, and would roll back gains in transparency. In case of fiscal decentralization, our suggestion is the creation a single nationwide purchasing pool which in our view would further increase efficiency and quality of service provision and would allow for greater cross-subsidization with a positive result on equity.

- Strengthening the MTBF process would provide an excellent tool for full integration of output-based budgeting system which is much needed to maintain the benefits of the

single-payer system, improve predictability in financing and allow the health sector to plan and allocate resources without the fear of ad hoc cuts in allocation during the annual budget cycle.

2 Introduction: why reform health care financing?

Kyrgyzstan inherited a health financing system similar to that of other countries in Former Soviet Union and Central-Eastern Europe. There were three government levels and each had its own vertically integrated health care system: republican level, oblast level and rayon/city level. Each level carried out all four functions of health financing and provision systems: collected revenues, pooled funds, purchased, and provided care. The source of health revenues were general taxes and all the population was entitled to a broad scope of services free at the point of service. Provider organizations received historical budgets with strict line-items, physicians received salaries.

The early transition period, with its economic decline and severe fiscal contraction, exposed similar problems in the Kyrgyz health system as in other transition economies of the FSU & CEE region. These problems included erosion in previously high levels of financial protection, inequitable distribution of public resources disproportionately favoring tertiary facilities in the capital city, inefficiently large service delivery sector, and quality problems.

Drastically reduced public funding for health care combined with rising input prices led to shortages, erosion of financial protection and growth in informal payments. The decline in overall government spending also meant a decline in government health spending. At the same time, prices for key inputs, such as medicines and energy, increased. The health system thus had to function with less money while faced with higher prices. As in all transition countries, the effect of these combined factors included shortages of medicines, the accumulation of arrears for public utilities, and the rise of “informal payments” for care. The presence and growth of these payments meant that the system had become less transparent.

Fragmented pooling arrangements undermined risk protection and equitable distribution of public resources. Since financing was so decentralized, each administrative level was responsible for finding resources for a relatively small number of people. Fragmentation of financing arrangements did not allow re-distribution across administrative levels; hence, it was not possible to cross-subsidize from richer to poorer rayons.

Fragmented organization of vertically integrated financing and delivery systems prevented restructuring of health care facilities and improvement of efficiency. Each government level funded its own facilities through a hierarchical integrated line item budgeting process: republican level institutes were funded from republican level taxes, oblast facilities were funded from oblast taxes, and rayon/city facilities were funded from rayon/city taxes. Because each administrative level funded its own facilities, there were no incentives and possibilities to cooperate across administrative levels and merge resources and facilities where needed beyond some limited cross-oblast and cross-rayon equalization mechanisms. Instead, each level struggled to find the resources it needed to keep its own facilities open and running. Thus, without changing the financing structure, restructuring could not have taken place.

Lack of incentives for efficient use of resources and high quality care. The service delivery infrastructure was too large with too many hospital buildings and in some places even too many personnel. In part, this duplication arose because the fragmented financing system led to the presence of both oblast and rayon/city health facilities in the same territory, particularly in the capital city of each oblast (e.g. oblast maternity hospital, city maternity hospital) and of course between Republican and Bishkek city facilities. In part, excess capacity arose because providers were faced with incentives that did not promote efficient use of resources, nor high quality care. Allocation of resources to providers at all

administrative levels was based on input-based norms and reflected historical patterns. The more beds a hospital had, the more staff positions it was allowed to have and the greater budget it received. Managers could not re-allocate across line-item categories if need or the opportunity arose. Decline in public funds made this inefficiency painfully visible as much of public funds were swallowed by the utility costs and maintenance.

The sum of these problems meant that Kyrgyzstan – as other countries in the region – had two choices. First, it could do nothing and let the health system decay, let the population shoulder an increasingly greater share of the health financing burden from their own pockets, and see the growth in informal payments as doctors tried to complement their meager salaries. Or it could cut to the heart of many of the problems in the post-soviet health systems and radically transform the inherited health financing arrangements.

Many factors coincided to explain why Kyrgyzstan opted for the latter and developed and implemented a novel model of health care financing. One key factor was surely the visionary leadership in the health sector which was backed by strong high level political support. Additionally, the coordinated support of donors and their technical guidance created an encouraging and supportive environment for medium-term health financing reforms to be implemented.

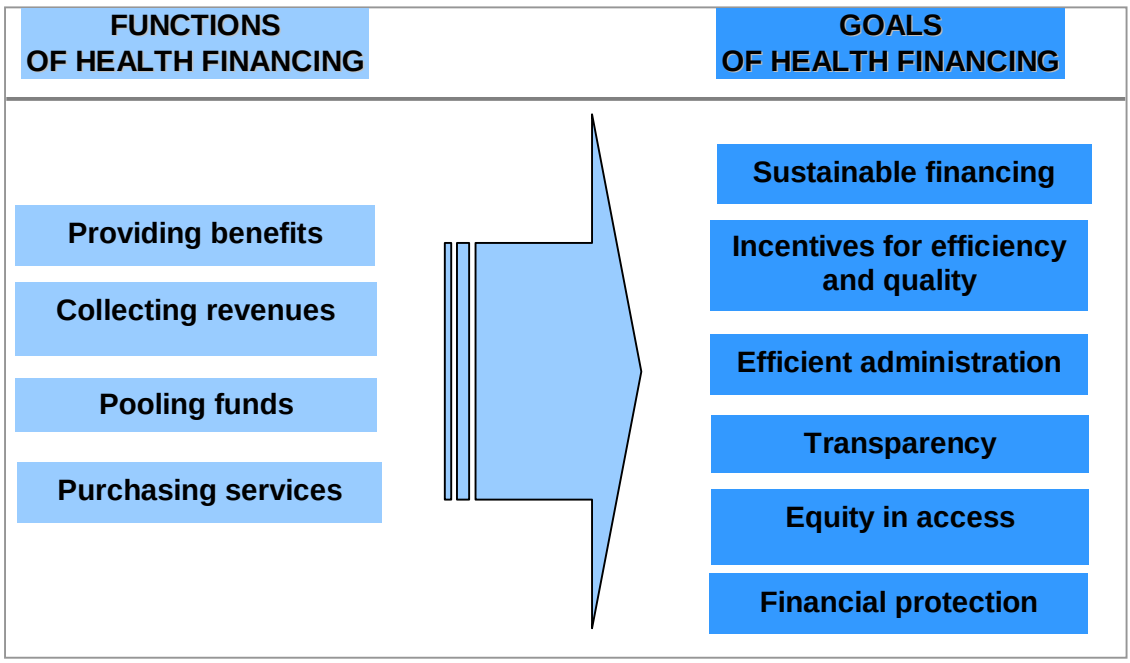
The road, however, has not been easy and the health financing reforms continue to draw debate and discussion regarding its merits and shortcomings. This debate has become particularly acute as the Kyrgyz government embarked on designing the next phase of its health sector strategy for 2006-2010. The discourse on the Kyrgyz health financing reforms is impressively sophisticated and shows that the decade of health financing reform has greatly increased the capacity in the Kyrgyz health sector. Nevertheless, there have been instances when this debate was not based on systematic evidence.

The purpose of this paper is to contribute to this discourse by providing a comprehensive evaluation of the implemented health financing reforms to date. We will present both previously presented as well as new evidence regarding the achievements and the remaining challenges of the implemented financing system.

3 Analytical Framework

To evaluate the Kyrgyz health financing reforms, we combine two analytical frameworks. The first one is the functional approach of the WHO health system framework proposed in the World Health Report 2000. The second one is an extension of WHO framework proposed by Kutzin specifically to evaluate health care financing arrangements. (Figure 1)

Figure 1. Analytical framework for health financing



Source: WHO, 2001; Kutzin, 2005

We break-down the description of the Kyrgyz health financing reforms in Section 4 according to the functional classification of WHO. We discuss the Kyrgyz health financing reforms in terms of the arrangements for the following functions:

- Providing benefits to the population (section 4.1)
- Collecting resources (section 4.2)
- Pooling funds (section 4.3)
- Purchasing services (section 4.4)

To evaluate the effects of these reforms on health system goals, we use the approach proposed by Kutzin of combining broad system goals with more specific objectives for health financing policy. Some of these health financing goals are essentially synonymous with health system goals (e.g. financial/risk protection) while others reflect the contribution of health financing arrangements to the wider goals (e.g. putting in place incentives for efficiency and quality). This latter is because there are many factors that influence how the health system performs on efficiency and quality, not only the health financing arrangements while these arrangements can be evaluated at least based on whether they provide incentives for providers for efficiency and quality.

Based on this logic, we discuss reform impact along the following dimensions:

- Generating sufficient resources to meet health system objectives (section 5.1)
- Providing explicit incentives for providers that promote quality and efficiency in service delivery (section 5.2)
- Administering the financing system efficiently (section 5.3)
- Transparency (section 5.4)
- Ensuring equal access to health care services (section 5.4)
- Providing financial/risk protection (5.6)

We conclude our review by a discussion of the lessons learnt in implementing health financing reforms in Kyrgyzstan (section 6) followed by a discussion of the unfinished agenda for Manas-II (section 7).

4 The Kyrgyz health financing reform

The Kyrgyz health financing model has become widely known as the "Single Payer System". This name captures the key idea of the Kyrgyz model which is the creation of single payer oblast level purchasing pools under the Mandatory Health Insurance Fund. In each oblast, there is one purchaser of health services, for those services that are part of the State Guaranteed Benefit Package (SGBP). These purchasing pools are called Territorial Departments of the Mandatory Health Insurance Fund (TDMHIF). All oblast and sub-oblast tax revenues are transferred to and pooled in these oblast purchasing pools. Public health services and tertiary services not included in the SGBP continue to be funded through budget resources through the Ministry of Health.

Since the Kyrgyz health financing system has been described extensively elsewhere, in this paper we provide only the highlights of the Kyrgyz system and we refer the reader elsewhere for a more in depth description[1]. The following sections describe the key reform steps in terms of providing benefits (4.1), collecting resources (4.2), pooling of funds (4.3), and purchasing (4.4). We also describe institutional arrangements for delivering these health financing functions (4.5) and the implementation process (4.6). We conclude the section by discussing the health financing reforms in the context of wider fiscal reforms in Kyrgyzstan (4.7).

4.1 Providing benefits

The entitlements of the Kyrgyz population to individual health services are defined in the State Guaranteed Benefit Package (SGBP). The Kyrgyz SGBP has the following features:

- Free primary care to all Kyrgyz citizens regardless of their insurance status
- Referral care to outpatient specialists and hospitals is against a set regulated co-payment
- Insured persons officially enrolled with the MHIF are entitled to a complementary package consisting of lower co-payment for referral care and access to an outpatient drug benefit.
- Some population groups are fully or partially exempt from paying co-payments. Providers receive a higher payment from the MHIF for treating exempted patients so that they do not have incentives to favor patients who can afford co-payment and they have positive incentives to treat persons in exempt groups. These population groups include low-income pensioners, cancer patients, TB patients, WWII veterans, etc. Hospitals also set aside a reserve fund to grant exemptions for those who cannot pay.

At the same time, there are important health services not included in the SGBP. These are population based services such as public health, some tertiary services delivered through Republican Institutes, and providers of parallel health systems (e.g. MoI, MoD). These services continue to be funded from republican budget resources through the responsible line-ministries including the MOH.

[1] For detailed description of introduced health financing reforms, see the following studies: Kutzin, 2003 PRP#21, 24; WHO-HPAP Policy Briefs #1, 2, 3, 7; (http://hpap.med.kg)

Table 2. Co-payment rates for admissions with surgery (2004)

	Partial Exempt	insured	uninsured	without referral
Bishkek, without Republican HF	260	900	1,602	2,330
Bishkek, Republican HF	260	1080	1,440	2,730
Chui	260	780	1,130	2,120
Issyk-Kul	260	780	1,130	2,070
Naryn	260	690	1,040	2,060
Talas	260	690	1,040	1,900
Osh	260	560	920	1,550
Osh city	260	650	1,020	1,740
Jalal-Abad	260	650	1,020	1,720
Batken	260	560	920	1,640

Source: MHIF

Table 3. Co-payment rates for admissions less costly surgery, or for diagnosis and medical treatment only (2004)

	Partial Exempt	insured	uninsured	without referral
Bishkek, not Republican HF	200	690	970	1,790
Bishkek, Republican HF	200	830	1,110	2,100
Chui	200	600	870	1,630
Issyk-Kul	200	600	870	1,590
Naryn	200	530	800	1,580
Talas	200	530	800	1,460
Osh	200	430	710	1,190
Osh City	200	500	780	1,340
Jalal-Abad	200	500	780	1,320
Batken	200	430	710	1,260

Source: MHIF

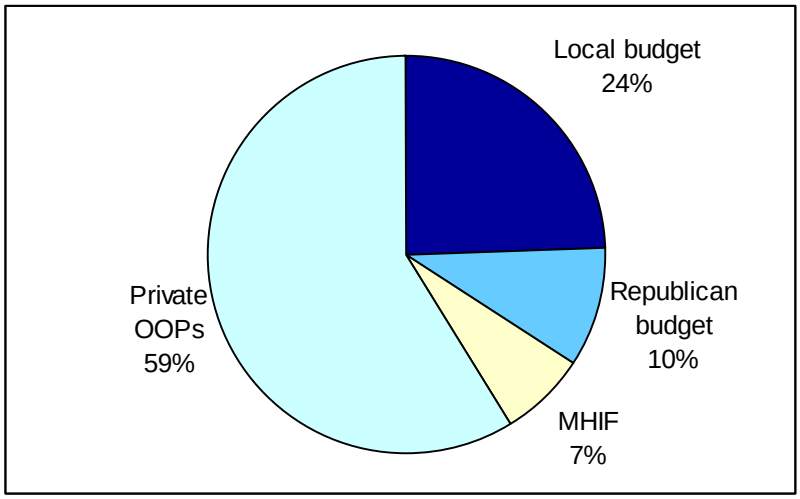
4.2 Collecting revenues

Revenues for the Kyrgyz health system originate from three sources: general tax revenues, payroll tax, and out-of-pocket payments. **General tax revenues** include Republican level taxes and oblast and sub-oblast taxes. Tax revenues are predominantly collected from indirect taxes mostly from VAT on tobacco and alcohol and excise taxes. Direct tax revenues through income and corporate tax play a small role in revenue generation for the Kyrgyz health sector.

Payroll tax is a *complementary* revenue source for the health sector raising 7% of total health revenues. It was introduced in 1997 as the source of funds for the Mandatory Health Insurance Fund (MHIF), the compulsory social health insurance fund. The payroll tax contribution rate has been 2% for the employed to be paid by the employer. Farmers working on their own land are required to pay the equivalent of 5% of their land tax for health insurance contribution. The pension fund is required to contribute 1.5 times the minimum wage on behalf of the pensioners, and the unemployment insurance fund is required to contribute the same amount on behalf of the uninsured. In 2000, coverage was expanded greatly by including children under 16 and social welfare recipients. Their coverage was

funded by direct transfers from the Republican budget to the MHIF. The MHIF does not collect revenue; its revenues are collected by the Social Fund.

Figure 2. Sources of health expenditures (by pooling agent) in 2003



Source: Treasury for public expenditure data and MHIF; KIHS-2004 for estimate of private OOP spending;
Note: Figures reflect the sources of heath expenditures by pooling agent. "Local budget" spending includes categorical grants received from the Republican budget. "MHIF" includes transfers from the Republican budget for children, pensioners, etc. "Republican budget" includes spending under the MOH. "Private OOPs" include household spending on formal co-payments for hospitalization, drugs, and informal payment and estimates are based on a nationally representative sample of 18,690 individuals.

Out-of-pocket payments include payments made at the point of service both formally and informally. There are two broad categories of formal payments. First are the "purely private" transactions such as the purchase of medicines from private pharmacies or payments made by patients to private physicians. Second are formal co-payments paid for outpatient specialist services, hospital admissions, and the outpatient drug package. Informal payments include payments made directly to health workers (mostly physicians) in government health facilities (or private facilities contracted by the MHIF for services in the SGBP) and payments for or provision of inputs (most frequently drugs and surgical supplies) or services that should be received for free as part of treatment. Official co-payments are required (i) for specialist outpatient care both in Family Medicine Centers (FMCs) and Ambulatory-Diagnostic Departments (ADDs); (ii) for inpatient care in hospitals; and (iii) for outpatient drugs covered by the Additional Drug Package obtained from contracted private pharmacies. Co-payment is not required for primary care. Patients who have paid official co-payment should not pay for drugs or directly to health care personnel. For specialist outpatient care, co-payment levels vary by type of service provided. For inpatient care, patients are required to pay a flat per admission fee.

The level of co-payment depends on three factors (Table 2, Table 3):

- admissions that involve surgical intervention require higher co-pay than those requiring only diagnosis and treatment; within surgical admissions there is a further differentiation into low-cost and high-cost surgical admissions

- insured patients pay a lower co-payment for referral services (outpatient specialist care and inpatient care) than uninsured patients;

- patients without referral pay a higher co-payment than patients with referral

4.3 Pooling of funds

The key feature of the Kyrgyz model of health financing is the pooling arrangement for budget funds at oblast level. In each oblast where SP reforms have been implemented, all sub-national budget funds for health care are pooled in the Territorial Department of the Mandatory Health Insurance Fund (TDMHIF). This means that oblast, rayon and city tax revenues are all transferred from local finance departments to the TDMHIF. The TDMHIF directly pays all providers in the oblast for the services they render. These funds are then matched by a complementary payment from the national pool collected from payroll taxes. For services outside the SGBP, the MOH acts as the pooling agency. Tax revenues are transferred to the MOH and then on to providers.

4.4 Purchasing services

The MHIF and its Territorial departments pay health care providers for the care they render. In primary care, Family Group Practices (FGPs) receive payment based on the number of people registered with them. Hospitals are paid based on the number of cases they treat and their severity. Providers fill out one form about the patients they treat and send one copy to the TDMHIF. There is a case-based payment for all patients made from the local budget-funded pool managed by the TDMHIF. If the patient is insured, this triggers an additional payment from the national MHIF pool. Payments from each pool are thus based on the same clinical information form, using the same method of payment. Only the source of funds they use to pay is different: each TDMHIF uses tax revenues provided by all the local governments (i.e. oblast including categorical grants, rayons and cities), and the MHIF uses payroll tax revenues collected by the Social Fund nationally and transfers from the Republican budget for the defined categories of insured persons. For services outside the SGBP, the payment mechanism has remained unchanged. It continues to be line-item budgets based on input norms.

4.5 Institutional arrangements

The MHIF was initially established as an independent para-statal organization under the government not subject to direct control by the MOH or MOF. In 1999, the legal status of the MHIF was changed to an independent legal entity under the MOH. The director of the MHIF is a deputy minister of health simultaneously.

The para-statal nature of the MHIF has been a critical enabling factor behind moving to new output based purchasing arrangements. Although it is conceptually possible for the MOH to fulfill the pooling function (at least for tax revenues), the MOH could not fulfill the purchasing function with as much embedded incentives for efficiency as the MHIF does. Current Kyrgyz legislation does not allow for output based payment and contracting mechanisms within the "core public sector". As we demonstrate later, a key success of the Kyrgyz health financing reforms is the downsizing and efficiency gains it triggered, and the key factor behind this achievement was the output based payment mechanism. Thus, had a different pooling arrangement been implemented without setting up an independent public organization with the ability to pay based on output, the Kyrgyz health financing reforms would have been undoubtedly less successful in triggering efficiency gains.

4.6 Reform implementation: from piloting to national roll-out

The single payer-reforms were implemented in a phased manner. In the first phase (1997-2000), the MHIF was managing only the payroll tax revenues and oblast purchasing pools were not yet in place. Yet, these four years were critical for institutional development. The MHIF developed its systems and skills, and especially the payment and information systems. A critical factor was the "joint systems", especially the joint information systems at hospital level. The MHIF was managing a small share of the funds, but it was also managing the data on every hospital admission. This enabled them to simulate the financial implications of switching to the new payments systems for budget funds and use this information to better plan the introduction of the oblast purchasing pools.

The second phase began in 2001 included the introduction of oblast purchasing pools. The MHIF became responsible for managing oblast and sub-oblast funds. At this time, the MHIF had already four years of experience and thus shifting from managing the small MHIF pool to managing the large local budget pools was less demanding and risky. Nevertheless the single-payer reforms were introduced through a phased step-by-step approach. The first pilots were conducted in Issyk-Kul and Chui oblasts in 2001. The reforms were rolled out to two additional oblasts every two years.

- 1st wave (2001): Issyk-Kul, Chui
- 2nd wave (2002): Talas, Naryn
- 3rd wave (2003): Jalal-Abad, Batken
- 4th wave (2003/04): Osh city and oblast, Bishkek city

This phased approach allowed learning-by-doing; ironing out initial problems; evaluating the early effects on the population; building capacity and confidence; and building capacity throughout the process.

5 Achievements and challenges for the Kyrgyz health financing reform

In this section, we assess the impact of the Kyrgyz health financing reforms along six dimensions of performance.

- Does the current health financing system generate sufficient resources to meet health system objectives? (section 5.1)
- Are there incentives for providers to promote quality and efficiency in service delivery (section 5.2)
- Is the health financing system efficiently administered? (section 5.3)
- Is the health financing arrangement transparent? (section 5.4)
- Does the health financing arrangement lead to equality of access or are there financial barriers that prevent access for the poor? (Section 5.5)
- Are individuals and their families are protected against the risk of impoverishing health expenditures? (section 5.6)

The evidence we present in the following sections are summarized in Table 4 below. The table lists the six dimensions of performance we are going to analyze and our assessment of the balance of the evidence. On each dimension, we allocated three points according to whether the evidence points to a significant success or continued challenge or both.

The strengths of the Kyrgyz health financing reforms so far have been improving the equity of the benefits people receive, improving transparency, efficiency and quality of services, and functioning with remarkable administrative efficiency. The remaining challenges include improving financial protection by reducing the burden of direct payment on households which in turn requires generating sufficient resources from public funding.

Table 4. Summary of performance assessment

	Significant progress	Continued challenge
1. Generating sufficient resources to meet health system objectives		ü
2. Incentives for efficiency and quality	ü	
3. Administrative efficiency	ü	
4. Transparency	ü	
5. Equity in access	ü	
6. Providing financial/risk protection		ü

5.1 Does the health system generate sufficient resources to meet health system objectives?

In this section, we explore trends in health expenditures during 2000 and 2003. Our main argument in this section is that the Kyrgyz health system faced significant challenges to generate sufficient **public** resources for the health sector during this period to ensure

meeting health system objectives. In the absence of adequate public funding, households shouldered a greater share of health financing through out-of-pocket payments which in turn undermines financial/risk protection. Trends began to show improvement in 2003/2004 and it is critical that these recent positive achievements in the flow of public funding remain a priority for the coming years. We begin our discussion with trends in total health expenditures (5.1.1) followed by an analysis of public expenditures (5.1.2) and private expenditures (5.1.3).

5.1.1 Total health expenditures

The Kyrgyz Republic spent 5% of GDP on health care in 2003. This is nearly equally distributed between public and private sources: 44% of health revenues is raised from public sources through taxes and payroll taxes and 56% of health revenues is raised through out-of-pocket payments of households for visits, drugs, and hospitalizations. The annual growth rate of per capita health expenditures in real terms averaged 11% between 2000 and 2003, with the collection of payroll tax funds and out-of-pocket payments increasing rapidly, and general tax revenues increasing moderately. (Table 5)

Table 5. Public-private shares and total health expenditures

	2000	2001	2002	2003	Annual average growth rate
As share of GDP					
Budget	1.9%	1.7%	1.9%	1.8%	-0.9%
MHIF	0.2%	0.2%	0.2%	0.4%	23.0%
Private	2.3%	2.6%	3.0%	3.2%	11.8%
Total	**4.4%**	**4.4%**	**5.1%**	**5.3%**	**7.0%**
As share of total health expenditures					
Budget	42.2%	38.5%	36.8%	34.0%	-6.5%
MHIF	4.9%	4.0%	4.3%	6.8%	13.2%
Private	53.0%	57.5%	58.9%	59.3%	4.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**
Per capita health spending nominal (in soms)					
Budget	247.5	255.7	283.1	300.6	7.2%
MHIF	28.5	26.9	33.4	60.0	36.8%
Private	310.8	382.0	453.2	524.4	22.9%
Total	**586.8**	**664.6**	**769.7**	**885.0**	**16.9%**
Per capita health spending real 2000=100 (in soms)					
Budget	247.5	243.2	263.6	286.3	5.2%
MHIF	28.5	25.6	31.1	57.1	33.5%
Private	310.8	363.4	421.9	499.4	20.2%
Total	**586.8**	**632.2**	**716.6**	**842.8**	**14.5%**

Source: Treasury for public expenditure data and MHIF; KIHS-2004 for estimate of private OOP spending; see WHO-DFID PRP# 28 for detailed explanation (http://hpap.med.kg)

Note: Figures reflect the sources of heath expenditures by pooling agent. "Local budget" spending includes categorical grants received from the Republican budget. "MHIF" includes transfers from the Republican budget for children, pensioners, etc. "Republican budget" includes spending under the MOH. "Private OOPs" include household spending on formal co-payments for hospitalization, drugs, and informal payment and estimates are based on a nationally representative sample of 18,690 individuals.

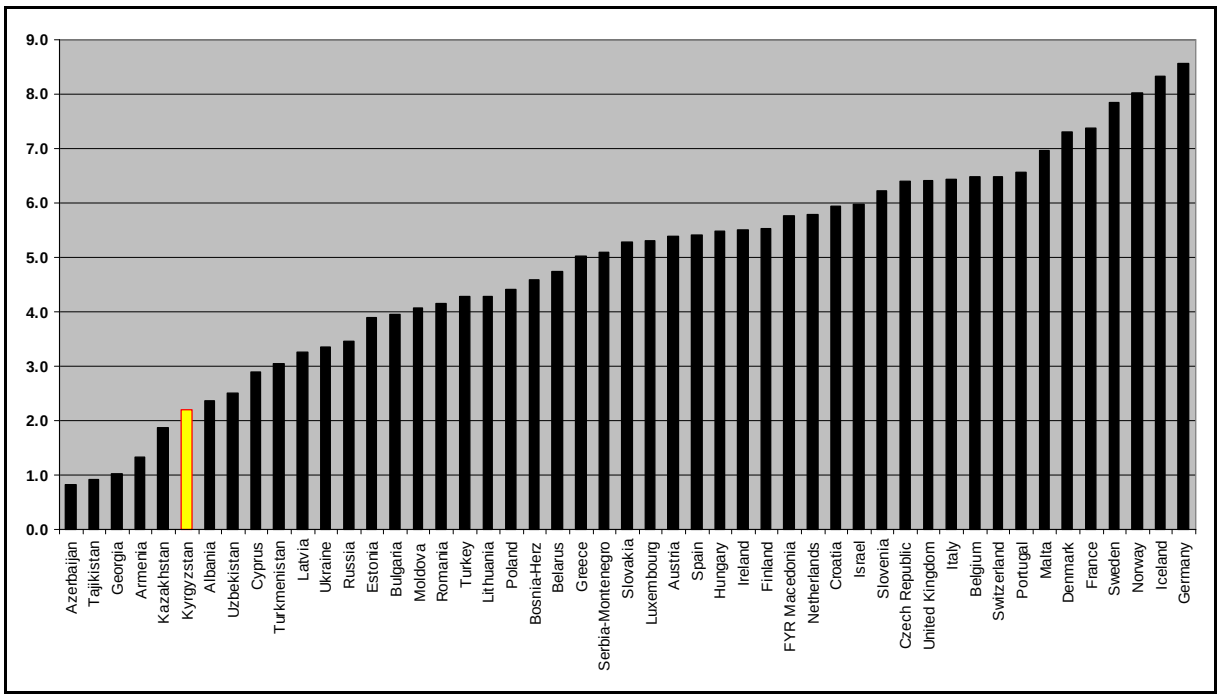
5.1.2 Public health expenditures

Despite recently recorded growth in public expenditures, Kyrgyzstan continues to place among countries with low public spending on health care with 2.2% of GDP in 2003. (Figure 3) Such low level of spending is not unusual for low-income countries reflecting difficulties of

tax collection and fiscal constraints. Low public expenditures on health are often treated as a given constraint that can only be addressed with social and economic growth and a more formal economy.

Nevertheless, we believe that low level of public spending should not be taken as given in the Kyrgyz context even considering the state of tax administration and fiscal constraints. In the Kyrgyz case, the health sector has been receiving a smaller and smaller **share** of public resources available since 1996. This decline occurred both at the level of the Republican and Oblast budgets. (Figure 4) This indicates that the part of the problem is not so much tax collection difficulties or fiscal constraints but a de-facto prioritization away from the health sector. Thus, even in the absence of any progress in public revenue collection, at least maintaining the share of the health sector in the government budget would allow the government to better meet its commitments in the CDF and PRSP.

Figure 3. Public spending on health as % of GDP in 2002 in selected European countries



Source: WHO staff estimates, World Health Report 2005

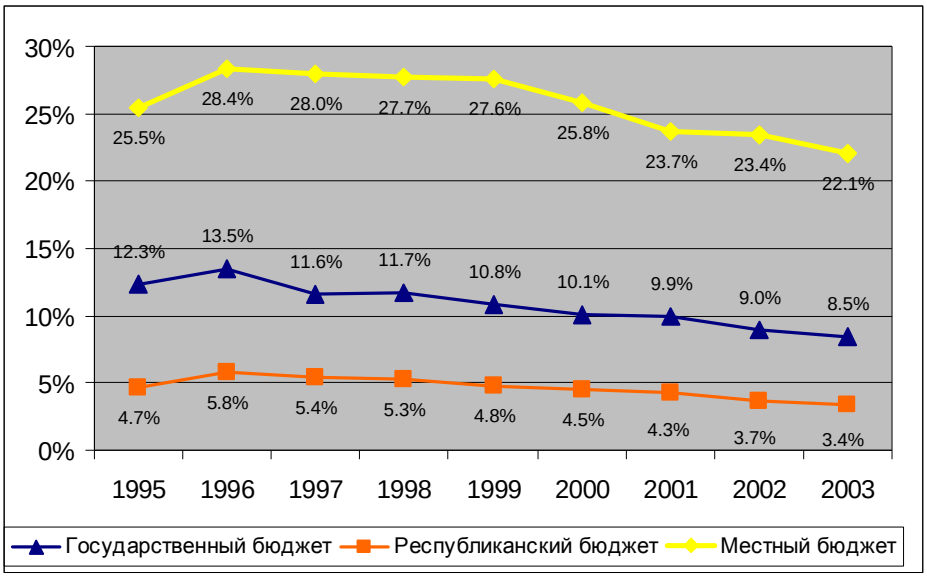
Most criticisms of the Kyrgyz health financing system can be attributed to insufficient and inconsistent funding flows to the health sector. This included insufficient public funding allocated to meet obligations in the social contract expressed in the SGBP. This also included inadequate fulfillment of legally obligated funds including variable budget execution, regular sequestration, and insufficient transfers from the Social Fund to MHIF. These factors have created a difficult situation for the MHIF on a daily basis to continue to meet contractual agreements to providers and to the population. This in turn was reflected in wages and availability of drugs and immediately drew significant discontent from key stakeholders. We highlight some of these problems in detail below with the hope that greater attention will be paid to these issues in the future.

Oblast funding began to decline in the wake of successful restructuring (which meant fewer hospital beds and staff). Oblast level pooling and output based payment have achieved their intent: the Kyrgyz health system underwent significant downsizing and became slimmer over 1996-2003 with resultants gains in utility and maintenance costs. However, the rest of the public sector has not taken the same giant steps as the health sector to move to output based payment of public providers. Declining staff and beds

triggered the well-instilled response of the Soviet budgeting system: if inputs decline, so should public funds. This mechanistic response has effectively taken out savings from the health sector reducing provider incentives to embark on painful downsizing processes elsewhere.

The introduction of co-payment had a similar crowd-out effect on public spending. The period of accelerated decline in public funding, especially at oblast level, coincided with the introduction of co-payment. This seemed to create a crowd-out effect in budget negotiations and marginal resources were allocated to those sectors that did not have a chance to collect additional revenues through co-payment. The problem with excessive reliance on co-payment is that it is the most regressive health revenue and undermines financial protection for the sick. The logic presented above signals that it was overall not well understood that co-payment was meant as complementary and additional revenues for the health sector and not as substitutes for general tax revenues. (For a detailed discussion, see Kutzin PRP 24, 2003)

Figure 4. Health expenditures as share of government budget

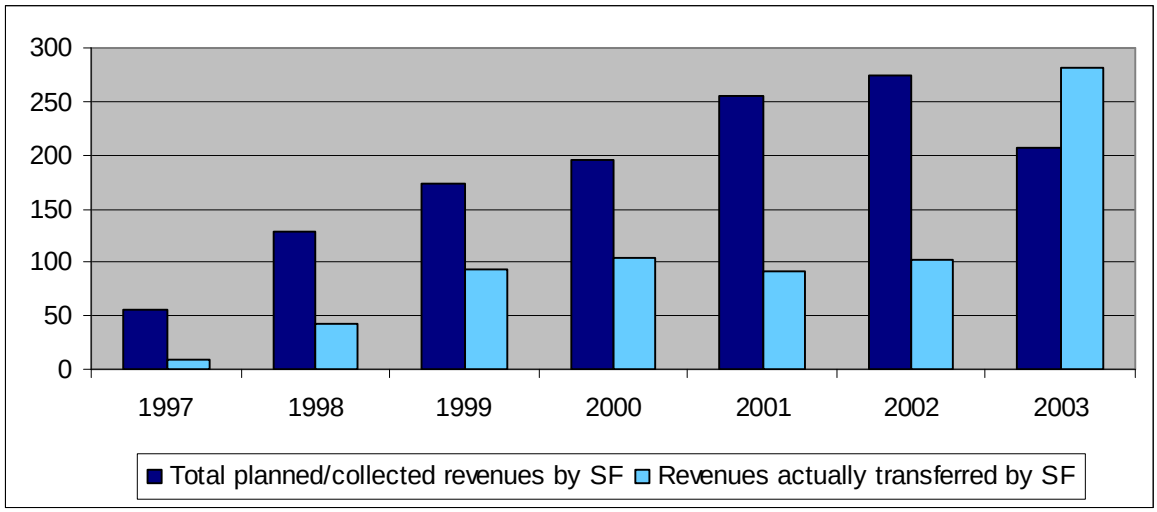


Source: Treasury, MHIF

Transfers from the Social Fund to the MHIF have not been appropriately fulfilled, particularly in 2000-01, creating immense operational difficulties for the MHIF. (

Figure 5) While the separation of collection and pooling responsibilities between the Social Fund and MHIF were well-defined, the amounts allocated to the MHIF were always less than the amounts that should have been transferred. The reasons for this non-transfer of revenues by the Social Fund are related to its own financial problems, but the consequence of this is that the money meant for the MHIF is effectively cross-subsidizing other programs, particularly pensions. The IMF conditionality was introduced to amend the situation and the experience of 2003 shows a great improvement although arrears remain.

Figure 5. Social Fund Transfers to the MHIF



Source: MHIF

Republican transfers to MHIF on behalf of children and social welfare recipients have been low and budget execution has been particularly problematic. In response to the annual shortfall between demands for public funding and revenues, the MOF has pursued the policy of first funding salaries and pensions (so called protected items). This meant that the health sector has suffered in those areas where the budget was no longer formed based on line-items but on a programmatic basis. As a result, children's and pensioner's health insurance dos not fall under these priority categories or "protected items" and tended to have lower budget execution as compared with other programs. As a result, the average budget execution between 2000 and 2003 was 49 percent for these programs. In 2003, budget execution was particularly poor (33 percent). This is much lower than overall budget execution for most sectors including the MOH. (Table 6). Gaps in financing for these programs meant that the MHIF has steadily built-up arrears to health care providers. Large MHIF arrears to providers discredits the health reforms and also make the MHIF a bad business partner. On a positive note, budget execution in 2004 registered a remarkable improvement for these special programs: 94% for children's health insurance, 98% for social beneficiaries, and 72% for pensioners'.

Table 6. Estimated costs of the SGBP, transfers, and budget execution for vulnerable categories

	2000	2001	2002	2003	2004
Children's Health Insurance					
Planned transfer to MHIF (mn soms)	35	52	71.7	90.3	57.8
Actual transfer to MHIF (mn soms)	25.5	24.7	46.3	30.6	54.6
Budget execution (%)	**72.90%**	**47.50%**	**64.50%**	**33.90%**	**94%**
Social beneficiaries					
Planned transfer to MHIF (mn soms)	5	8	8.5	6	6
Actual transfer to MHIF (mn soms)	4.2	2.2	5	3.4	5.9
Budget execution (%)	**84.00%**	**28%**	**60.20%**	**56.90%**	**98%**
Pensioners					
Planned transfer to MHIF (mn soms)	-	-	-	-	40
Actual transfer to MHIF (mn soms)	-	-	-	-	28.9
Budget execution (%)	**-**	**-**	**-**	**-**	**72%**

Source: MHIF and World Bank calculations

In contrast, local budget execution, especially in better-off areas such as Bishkek city and Chui is very good (almost 100 percent). The budget execution for categorical grants is also very good. This reflects the fact that there is an IMF conditionality related to CGs as well as the fact that CGs mainly cover salaries which is a protected item. Under the GSAC, starting in the 2006 budget, CGs will be calculated on the basis of a formula (output-based) identified on the basis of the minimum service standards. Then CGs will no longer be pegged to salaries and could potentially suffer from poor budget execution. To ensure that this does not happen, the next IMF PRGF agreement should continue the current conditionality on CGs that does not allow any build-up of arrears.

5.1.3 Out-of-pocket health expenditures

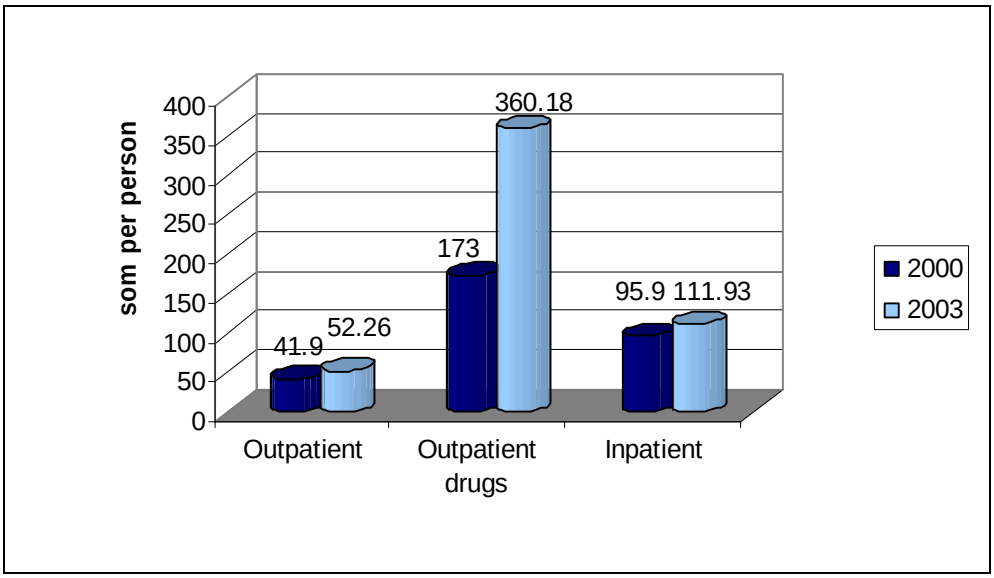
Private out-of-pocket health expenditures in Kyrgyzstan provide more than half of the resources for the health sector. There are two broad categories of formal payments. First, there are the "purely private" transactions such as the purchase of medicines from private pharmacies or payments made by patients to private physicians. Second, there are formal co-payments paid for outpatient specialist services, hospital admissions, and the outpatient drug package. Informal payments include payments made directly to health workers (mostly physicians) in government health facilities (or private facilities contracted by the MHIF for services in the SGBP) and payments for or provision of inputs (most frequently drugs and surgical supplies) or services that should be received for free as part of treatment.

In contrast to public expenditures, out-of-pocket payments have been growing rather fast and at a rate faster than the growth rate of GDP. This in itself is not alarming and conforms to the experience of many countries: as households get richer they spend a greater and greater share of their household resources on health care. Nevertheless, out-of-pocket payments are the most regressive revenue source. The greater the share of OOP's in the health financing mix, the less financial protection households enjoy.

The figure below illustrates that the growth rate of health expenditures is fueled by fast increasing household spending on pharmaceuticals. Decomposition of pharmaceutical expenditures shows that this increase is due to both a price and a quantity effect. The per capita number of prescriptions has increased by 14% between 2000 and 2003. This may reflect changing treatment patterns with less emphasis on hospitalizations, and more aggressive pharmaceutical treatment at outpatient level. The price-per-prescription increased by 60% during this same time-period. This is a steep increase which deserves greater policy attention from the Ministry of Health to the pricing practices of pharmaceutical companies. Reasonable market regulation and pricing practices are important both for the purposes of protecting households from catastrophic medical expenditures and ensuring cost-control for public resources.

Household expenditures on hospital care and outpatient care increased only moderately during the time period. In both cases, we see an increase in the price of utilization (i.e. in the mean outpatient spending per visit and per hospitalization). At the same time, we see a decline in service utilization (visit rate, hospitalization rate). The result of increasing price and declining utilization is a moderate increase in expenditures.

Figure 6. Mean out-of-pocket expenditures by spending category



Source: HBS-2000, KIHS-2004 based on nationally representative household survey with 18,690 respondents. (For more details, see WHO-DFID HPAP PRP #28 downloadable from http://hpap.med.kg)

5.2 Providing incentives that promote quality and efficiency in service delivery

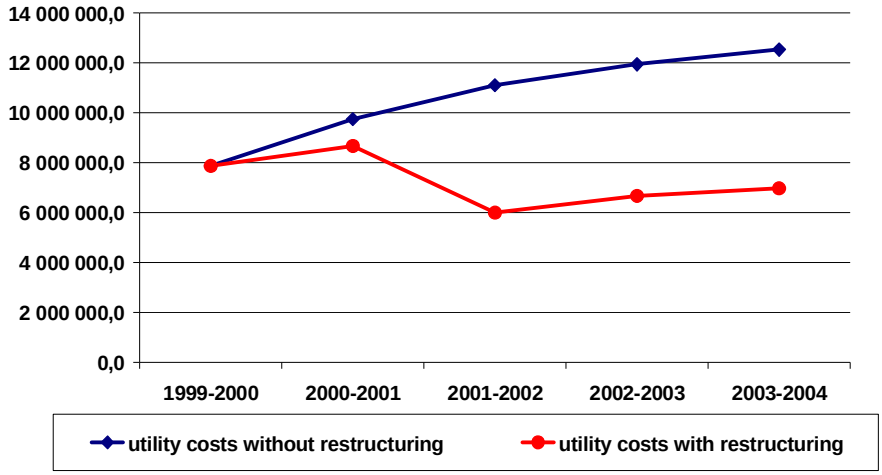
One of the key achievements of the Single Payer system is the successful introduction of "strategic purchasing". The key instruments of strategic purchasing include the introduction of output based payment mechanisms, cleverly structured incentives for referrals and exemptions, the Additional Drug Package and regular monitoring of quality. All these tools have provided explicit incentives for efficient and high quality provision of health care. This has led to documented improvements in efficiency of service delivery as we demonstrate below. The effect of strategic purchasing on quality is more difficult to assess. In primary care, we have solid documentation that primary care reforms – including strategic purchasing – have improved quality. However, we do not have the same extent of documentation for hospital care.

The new provider payment methods associated with the Single Payer system triggered the tremendous downsizing that occurred in the hospital sector between 2000 and 2003[2]. The previous input based historical budgets encouraged increased hospital capacity and long lengths of stay. The move to output based payment changed these incentives to increase productivity and reduce fixed costs. This led to the closure and consolidation of buildings and large reductions in the areas of occupied space required to operate the hospital sector. Between 2000 and 2003, 42% of the buildings and 35% of the floor space has been reduced.

In coordination with the reduction in square footage and closing of buildings, there has been a major effort to reduce utility expenses through improved planning and control processes including major improvements in insulation methods and techniques. Analysis of eight hospitals in Chui, Issyk-Kul, and Naryn oblasts also show that restructuring led to a substantial decline in utility costs in the 2001-02 heating period as compared to 2000-01. (Figure 7)

[2] See Purvis, Seitalieva et al 2005. Restructuring the Kyrgyz Health System 1996-2005: Impact on Efficiency and Access. WHO-DFID HPAP Policy Research Paper No. 30

Figure 7 Comparison of utility costs with and without restructuring in 8 investigated hospitals, Kyrgyz Republic, soms



Source: Checheibaev, E. 2004. "On Impact of the Health Facilities Restructuring on Public Utilities' Costs" WHO-DFID HPAP Health Policy Research Paper #27 Bishkek, Kyrgyz Republic

Reduction in physical and human resource infrastructure allowed spending a greater share of resources on direct patient care such as drugs and medical supplies rather than on utility expenses. Between 2000 and 2003, the share of health expenditures allocated to direct patient care expenses increased from 16% to 36%. This large reallocation of expenditures would not have been possible without significantly downsizing the infrastructure of service delivery.

The health financing reform was an important precondition for restructuring to take place. Without the new provider payment mechanisms, there would have been no incentives for downsizing as budgets used to be determined on an input basis. Restructuring, on the other hand, reinforced the financial incentives of the single payer reforms. The increase in public funds going to direct patient care allowed hospitals to be better stocked with medicines which in turn reduced patient incentives to pay informally for drugs and to the doctors when admitted to the hospital. This also illustrates how carefully orchestrated this cycle was and how dependent it is on the maintenance of public funding. If public funds decline as restructuring is taking place, hospitals are not able to use their savings to purchase medicines and other supplies patients will not see the benefit of the reforms.

The introduction of strategic purchasing has also led to improved quality at the level of primary care. Monitoring reports and recent studies point to the improved competency of primary care doctors, increased scope of primary care services, reduction in hospitalizations for primary care sensitive conditions, increased adherence to treatment guidelines and tremendous benefits associated with the Additional Drug Package in terms of availability and affordability of drugs for primary care sensitive conditions[3]. As use of the ADP increased, for example, hypertensive crises were reduced, as were referrals to hospital for conditions related to hypertension.

[3] For a good summary of the achievements of primary care reforms see Atun, R. 2005. "Evaluating the Manas Health Sector Reform: Focus on Primary Care". WHO-DFID Health Policy Analysis Project Policy Research Paper No. 29. (http://hpap.med.kg)

In contrast, there is limited reliable information about the quality of hospital care and building up this information base is an important area for the next phase of the reforms.

Box 1. Restructuring in Issyk-Ata Hospital

At the beginning of 2001, Issyk-Ata rayon in Chui oblast had 580 hospital beds distributed as follows: a CRH with 305, a "numerical hospital" with 125, and 6 SUBs ranging from 10 to 60 beds. In preparation for the introduction of the new financing system, a plan was developed to restructure the system to reduce costs while maintaining access to needed services. The plans were implemented, and by the end of the year, the inpatient care delivery system was reduced by 300 beds organized as follows: Territorial Hospital (former CRH) with 190 beds, plus three branches of the TH: one with 70 beds, and two with 10 beds each.

As a part of this restructuring, 28 buildings were put out of operation, and additional measures were taken to reduce utility costs (e.g. installing meters, challenging bills from the utility companies). Restructuring also involved staff, with the number of positions in the rayon reduced by 543 (33% of total), including 57 physical persons.

The co-payment revenues also allowed for additional expenses to be made for drugs, medical supplies, food, and staff salary supplements. As a consequence of these various changes, utility expenses in the rayon's health facilities were reduced by 1.1 million soms, which allowed for a substantial reduction in the debt of the hospitals for heat and electricity. The overall debt of the health facilities was reduced by 93% during 2001. Average salary payments to staff increased by 2.4 times as compared to 2000, average expenditure for drugs per case increased by 2.7 times, and for food by 2.35 times. Overall treatment expenses (i.e. for variable cost items) rose to 36% of inpatient care expenses in 2001 from 12% in 2000.

(Source: Isakov 2002).

All in all, the evidence clearly indicates that strategic purchasing and new incentives put in place have contributed to greater efficiency and quality of health care services. In part, the success of implementing this aspect of the reforms was due to the "para-statal" nature of the MHIF. For instance, if the MOH was the pooling agency for health care funds, it would not be able to purchase services "strategically" and would have to return to the use of hierarchical line-item input control. Under the current Treasury arrangements of the Kyrgyz public finance system, the MOH budget department would legally have to "budget" all government health facilities, rather than enable these facilities to "earn income" the way they do now from the MHIF. Input-based budgeting was a major source of inefficiency in the system inherited from the USSR. Such a re-introduction of the old budgeting system would reduce provider autonomy and hence their ability to respond quickly to changing circumstances. Undoubtedly, this would prevent further efficiency gains, and supporting quality improvements through financial incentives would also be difficult.

5.3 Administering the financing system efficiently

The MHIF, including its Territorial Departments, have responsibility to manage both local budget funds (a responsibility formerly implemented by oblast health or finance departments, and rayon finance departments) as well as the payroll tax and Republican budget transfers for the insured population. The administrative expenses of the MHIF are limited to a maximum of 5% of the payroll tax revenue that it receives from the Social Fund (even though its responsibilities for budget funds are much larger than for payroll tax revenues).[4] Its ability

[4] See Kutzin and Murzalieva (2001). "A note on administrative costs and functions of the Mandatory Health Insurance Fund." WHO-DFID HPAP Policy Research Paper 9. Available in English and Russian.

to manage these tasks, as well as a high volume of transactions, speaks to both its administrative efficiency and technical sophistication. As the table below illustrates, 5% spending on administrative expenditures is comparable to the administrative efficiency of other public health insurance systems.

Table 7. Administrative costs of public health insurance in selected countries

	Administrative costs as share of total health expenditures
Austria	3.6%
Belgium	4.8%
France	4.0-8.0%
Germany	5.1%
Ireland	2.8%*
Italy	0.4%*
Netherlands	4.4%
Spain	5.0%
UK	3.5%*

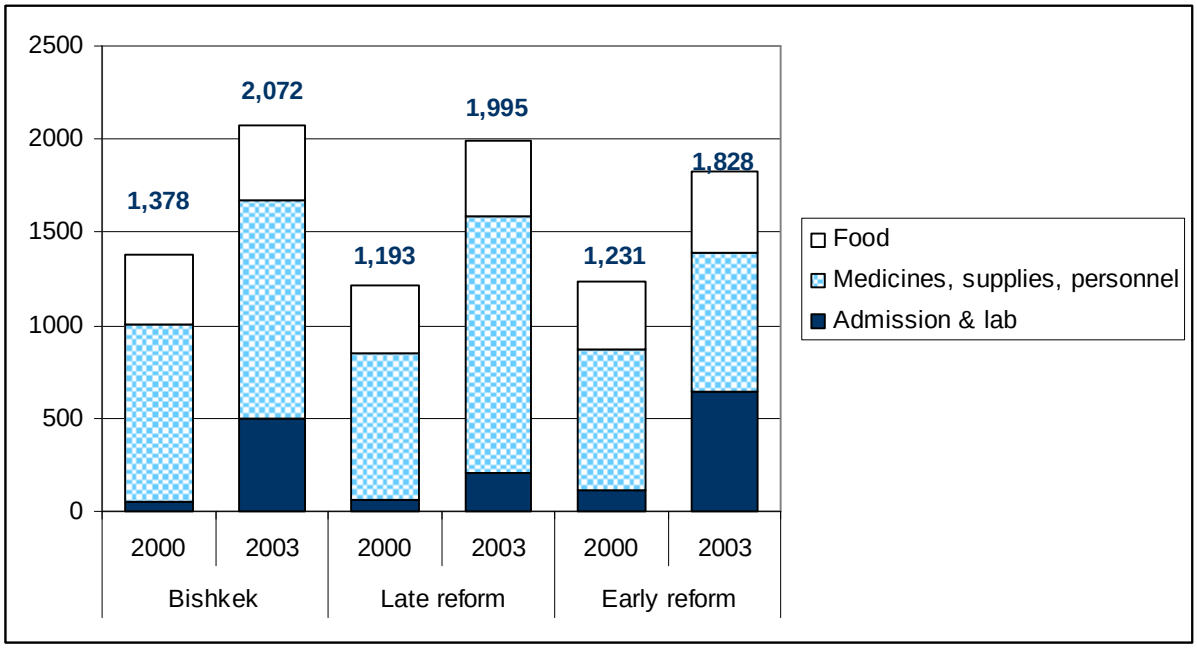
Source: Mossalios and Thomson, 2004.
Data for 1999-2000 except for Ireland, Italy and UK (1995)

5.4 Transparency

The Single Payer system has improved transparency of the health system for the population by creating a clear system of benefits and entitlements through the SGBP and the co-payment policy. Previously, the lack of clarity about entitlements coupled with great pressure on providers to replace markedly declined public funding led to a wide-spread system of informal payments, in particular for hospital care. Most hospitalized patients had to pay at the time of hospitalization informally to physicians, for medicines and various other supplies. However, there was no system of what patients were required to contribute in-kind and in-cash and physicians exercised price-setting as well as social justice of how much to ask of whom. Various surveys indicate that patients found this system poorly transparent, made them vulnerable to financial demands at the time of illness, and the cost of hospitalization was unpredictable as expenditures added up during the course of a hospital stay.

A key objective of the health financing reforms was to begin to make the health system more transparent by clarifying entitlements to benefits and responsibilities. As we show on the figure below, the single payer reforms have made significant progress in this direction. The figure below shows the decomposition of out-of-pocket payments for hospitalization and indicates the progress of the single payer reforms in slowing the growth of hospital payments and formalizing informal payments. The level of payment reflects the mean payment per hospitalization episode among those who were hospitalized in the public at least once in the year preceding the survey. The dark solid area is the level of expenditures made upon admission and for lab tests. The checkered area indicates payments for medicines, supplies, and personnel. If taking a conservative approach to the calculation of informal payment including only medicines, supplies, and payment to personnel, then informal payment is marked by the checkered area on the graph. The white area is the amount of payment made for food. Oblasts are grouped into three groups: (i) “early reform oblasts” marking Issk-kul, Chui, Naryn and Talas where the single payer system and co-payment were introduced in 2001-02; (ii) late reform oblasts including Jalal-Abad, Osh, and Batken where the single payer reforms and co-payment were introduced in 2003-04; and (iii) Bishkek separately (Bishkek fall into the group of late reform oblasts).

Figure 8. Mean payment for hospitalization among those hospitalized in the public sector



Source: HBS 2000, KIHS 2004; WHO staff calculations
Note: "Early reform" includes Issyk-kul, Chui, Naryn and Talas; "Late reform" includes Osh, Jalal-Abad, Batken. The checkered area (medicines, supplies, and personnel) is unequivocally informal payment as patients should receive these services free of charge against their co-payment. The dark blue area in 2000 is also largely informal payment, as there was no charge at that time for admission. In 2003, the dark blue area in early reform oblasts if formal co-payment but in Bishkek and late reform oblasts reflects a mix of co-payment and informal payment due to the varied timing of these policies.

The following two main conclusions can be drawn from this graph:

- The overall level of out-of-pocket payments made at the time of hospitalization grew at the slowest rate in early reform oblasts. This indicates some progress of the reforms in slowing the rate of growth in OOPs and the resultant burden on households.

- Informal payment increased in areas where the single-payer reforms and co-payment was introduced the latest and reduced in early reform oblasts. It grew by 73% in the late reform oblasts of Osh, Jalal-Abad, and Batken, and it grew by 24% in Bishkek. In contrast, informal payment reduced by 2% in the early reform oblasts of Issyk-kul, Chui, Naryn and Talas where the reforms have had a longer period to take hold.

In most recent times, there has been discussion about potentially changing the co-payment policy. Some argue for more refined categories according to case, case-severity, or some measure of socio-economic status. On the other hand, keeping the co-payment rates tractable has been a critical condition for its successful collection and monitoring. Explosion of rates would clearly not help either to collect more fees, or to significantly reduce the financial burden on the population. Any benefits of gaining satisfaction could be overwhelmed by the effect of confusion and gaming created by a complex fee schedule. Shaping the co-payment policy for the future should consider these trade-offs.

To inform this debate using population views, Table 8 tabulates results from the 2004 Health Module of the Kyrgyz Integrated Household Survey. The survey asked 3 questions about the co-payment policy after an introductory text reminding respondents about the current policy.

Table 8. Population perceptions of co-payment levels 2004

	Yes	No
Do you think people who stay in hospital for only 1-2 days should pay less than the current level of payment?	69.0%	31.0%
Do you think that someone with a severe form of illness should pay more than the current level of official payment?	19.0%	81.0%
If two people are hospitalized with the same condition (e.g. pneumonia) should the richer pay more than the poorer?	35.0%	65.0%

Source: KIHS-2004, WHO staff calculations

The following conclusions emerge:

- 70% of respondents feel that short hospital stays (1-2 days) should cost less than long hospital stays. This confirms concern and anecdotal evidence that the current co-payment is high relative to people's valuation of the benefits when patients are admitted for 1-2 days and mostly some test or observation is carried out. This would suggest alleviating the co-payment burden on short stays.

- 80% of respondent do not believe that people with more severe illness should pay more than the current level of payment. This suggests not introducing case adjustment or severity adjustment to the current rates.

- Finally, 65% of respondents think that the co-payment level should not vary by socio-economic status. This point does not correspond to "European" notions of fairness in health financing which imply that health care payments be made according to ability to pay. Most interestingly, this percentage stayed the same across the entire spectrum of socio-economic status. In all 5 quintiles of the income distribution, only 35% agreed that the rich should pay higher co-payment than the poor. This could reflect the view that people are viewing health care services like a commodity rather than a special good/service.

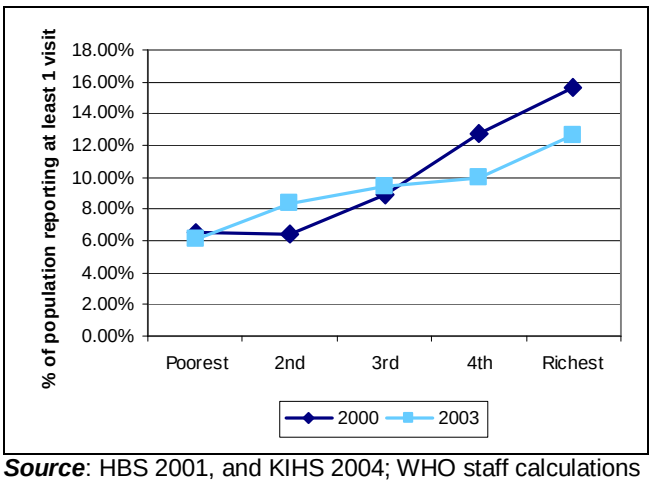
The analysis in this section suggests that the single-payer reforms and the co-payment policy began to exert a positive effect on limiting the growth of hospital out-of-pocket payments and improving transparency. The positive trends in early reform oblasts suggest that consistent and full implementation of the single-payer reforms would lead to similar benefits in other parts of the country over time. However, this benefit will only materialize is the flow of public funding becomes more predictable. Further reduction in informal payment is only possible with generating a stable and growing base of public resources for the health sector. This would translate into greater availability of drugs and more reasonable salaries for medical staff. The experience of other public sectors fighting corruption under-scores this conclusion: reasonable salaries and elimination of shortages are critical pre-conditions for further improvement of transparency.

5.5 Ensuring equal access to health services

The distribution of utilization of health care services across socio-economic groups has become more equal in 2003 than it was in 2000. This is the case for both outpatient and inpatient care. The health reforms appear to play an equalizing role on utilization across the country and across socio-economic status.

The dark line below shows the distribution of outpatient visits (primary care + outpatient specialist care) by expenditure quintile. (Figure 9) It shows that in 2001, the richest 20% of the population used outpatient services twice as frequently as the poorest 20% of the population. There was significant socio-economic inequality in the distribution of utilization. By 2003, the visit rate has dropped but it dropped uniquely among the richer half of the population. The poorest quintile experienced no change in their rate of visits, and we see a significant increase in visit rate for the second income quintile. On the whole, the distribution of utilization is showing a remarkable increase in socio-economic equality over the time-period.

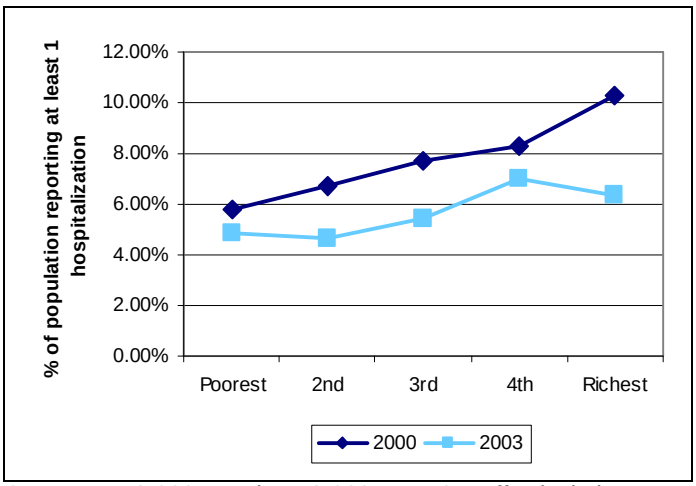
Figure 9. Access to outpatient care (primary care + outpatient specialist)



Source: HBS 2001, and KIHS 2004; WHO staff calculations
Note: The population was grouped into five quintiles using consumption data and quintile data calculated by the National Statistical Committee. Each quintile group contains 20% of the population ranked from poorest to richest.

Figure 10 below shows changes in the distribution of hospitalization rate. The dark line is for 2001 and again shows the presence of significant socio-economic inequalities. The richest 20% of the population used hospital care nearly twice as often as the poorest 20%. By 2003, the distribution of hospitalization rate has become more equal. The rich are using hospital care only slightly more frequently than the poor.

Figure 10. Access to hospital care



Source: HBS 2001, and KIHS 2004; WHO staff calculations
Note: The population was grouped into five quintiles using consumption data and quintile data calculated by the National Statistical Committee. Each quintile group contains 20% of the population ranked from poorest to richest.

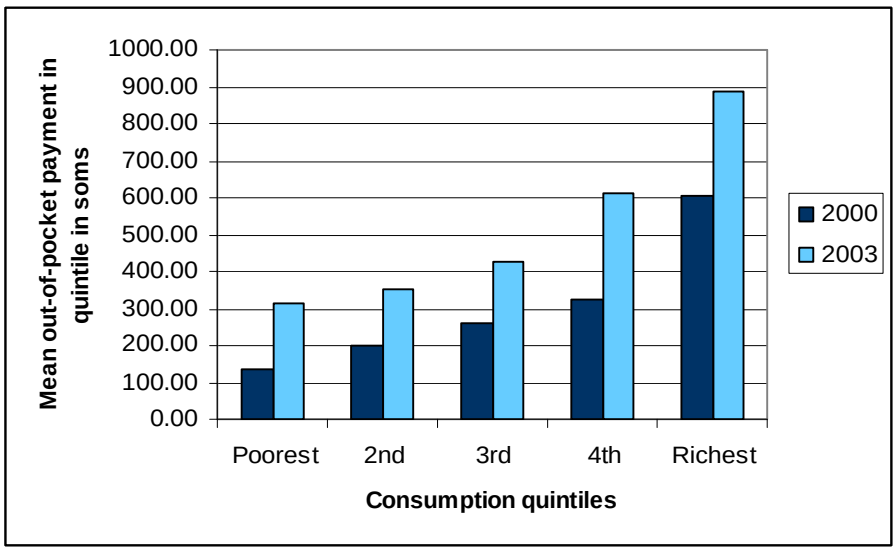
Utilization rate of hospitals declined for all socio-economic groups. For the poorest, it declined only marginally while it declined by 40% for the richest. We also see significant reduction in hospitalization rate for the middle quintile. While this findings needs to be further examined, it does not seem to signal significant increase in access barriers for the poor. The utilization rate of bottom 40% of the population relative to the top 60% is nearly the same. A much more likely explanation than access barriers to explain these findings is the changing treatment patterns of doctors. The new treatment modalities may be less reliant on hospitalization and more reliant on outpatient care and pharmaceuticals.

5.6 Financial protection

Although inequalities in utilization have become less pronounced over the past few years, seeking health care services continues to place a great burden on household resources through out-of-pocket payments.

Figure 11**Ошибка! Источник ссылки не найден.** shows the mean out-of-pocket health expenditures across consumption quintiles averaged over the entire population of that quintile regardless of reported health care use. Out-of-pocket payments include payments in outpatient setting, for outpatient drugs, and payment made at the time of hospitalization both formally and informally. In both years, the rich paid more for health care than the poor and the mean amount increased significantly across all consumption quintiles. The trend in the figure reflects the fact that forces affecting the growth of out-of-pocket payments, e.g. increase in drug prices, affect the poor and the rich equally.

Figure 11. Mean out-of-pocket payments by consumption quintile

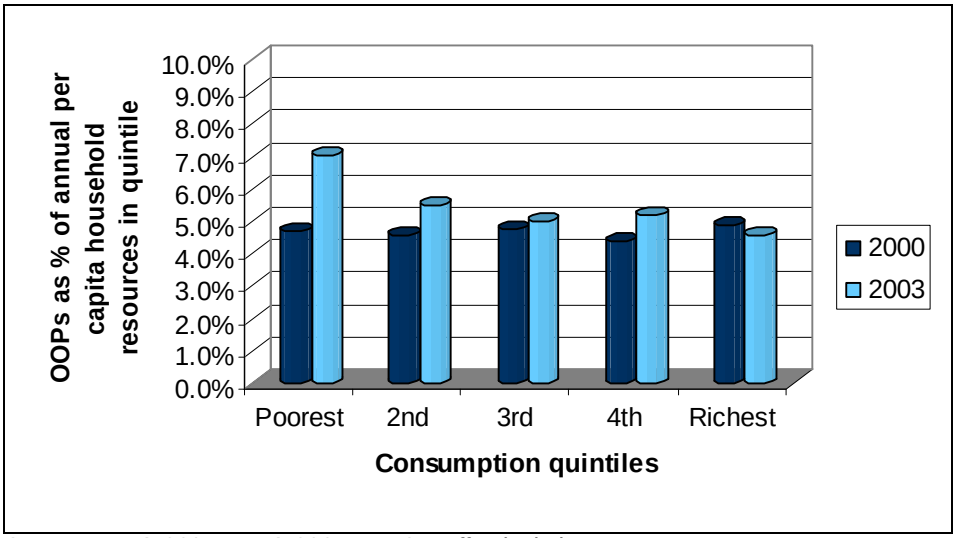


Source: HBS-2001, KIHS-2004; WHO staff calculations

Although the payments are lower in absolute terms for the poor than for the rich, they demand a greater share of household resources measured in terms of per capita consumption. (

Figure 12) The share of out-of-pocket payments in household resources grew significantly among the poorest quintile to 7% by 2003. The 2nd, 3rd, and 4th quintiles also devoted a greater share of household resources to health expenditures in 2003 than in 2000. The richest quintile experienced a slight reduction. This is mostly driven the declining utilization of health care among the rich (see Section 5.5).

Figure 12. Out-of-pocket payments as share of per capita household resources



Source: HBS-2001, KIHS-2004; WHO staff calculations

The above averages under-estimate the true magnitude of the burden of health care seeking for those households that experience an illness episode since these figures are averaged over the entire quintile of the population including those who were in good health during the year. Restricting the analysis to those individuals who reported a visit or a hospitalization, a starker picture emerges. In the poorest quintile, the conditional mean of out-of-pocket expenditures was 2,621 soms in 2003 while the per capita household resource was merely 4,511 soms. This means that for those individuals who reported a contact with the health system in the poorest quintile, out-of-pocket payments took up more than 50% of their annual per capita household budget. The corresponding amount for the richest quintile was 26%.

To assess the factors that drive the increase in out-of-pocket payments, we decomposed household health spending into theree groups: (i) spending at the time of outpatient visits (incl. lab and diagnostic test, specialist visits, private clinics, and informal payment); (ii) spending on drugs in the context of seeking outpatient care (i.e. excludes drugs purchased at time of hospitalization); and (iii) spending at time of hospitalization. (

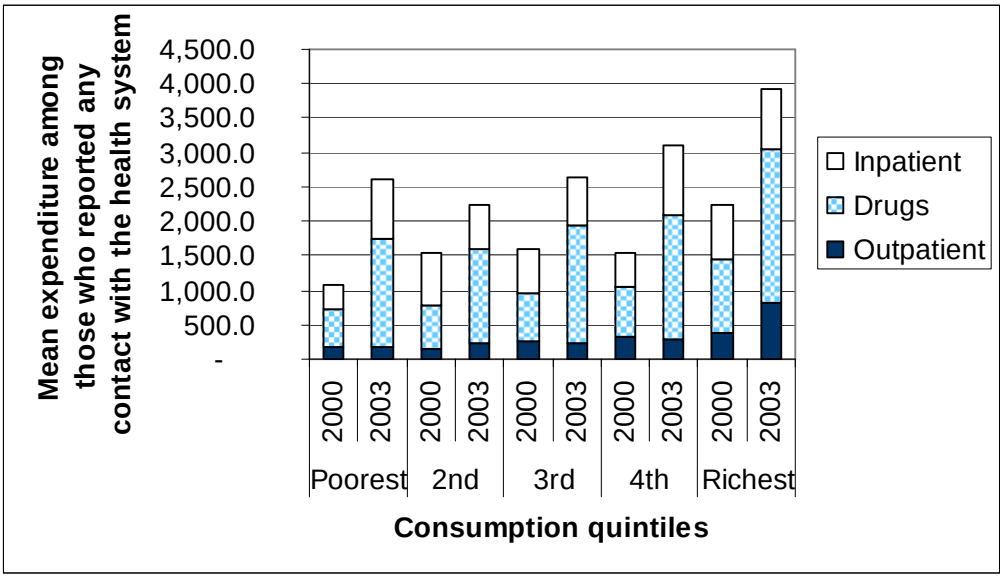
Figure 13) We restricted the analysis to those who reported an outpatient visit (and often resultant prescription) or hospitalization. Several interesting conclusions emerge.

- First, spending on pharmaceuticals is driving the growth of out-of-pocket payment in all quintiles. In another paper, we demonstrate that this is due to both a price and a quantity effect. People consume more drugs and drugs cost more. Revision of drug pricing and access is an important next step.

- Second, payments made at the time of hospitalization increased across all quintiles but the increase was most pronounced for the poorest. This is an expected outcome given that the flat co-payment does not differentiate across the poor and the rich. However, this also points to the weakness of the existing exemption mechanisms (see below) and hospital bed-funds in protecting the poor from the financial effects of co-payments.

§ Third, payments made in outpatient care are also increasing in percentage terms, and mostly among the rich. This is mostly due to the increased care seeking in private clinics in the capital and other major urban areas.

Figure 13. Decomposition of out-of-pocket spending among those reporting contact with the health system



Source: HBS-2001, KIHS-2004; WHO staff calculations

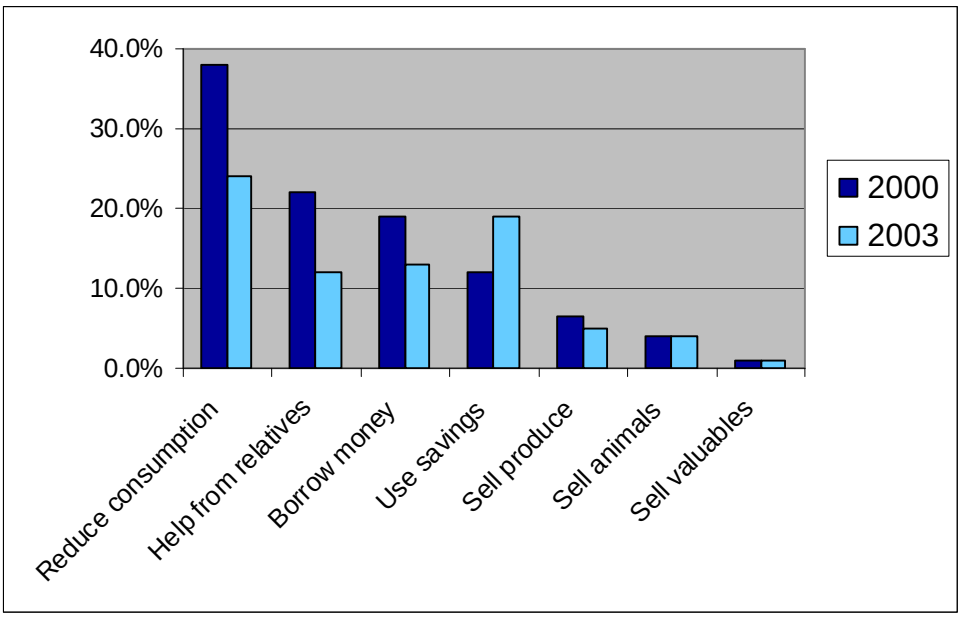
Earlier evidence points to the success of the exemption scheme to reduce the burden of expenditures on selected vulnerable categories[5]. In other words, those who are exempt pay less for health care. The problem is that the exemption categories themselves are not well targeted to the poor. There are two groups of exemptions. The first one is the inherited Soviet categories of war veterans, etc and the second group comprises of people in certain disability and illness categories (e.g. diabetes, asthma, etc). At the population level 2% of the population is exempt. In the 2004 KIHS we use for most of this analysis presented in this section, the exempt have the same mean consumption level as the non-exempt.

Coping mechanisms of households with high out-of-pocket expenditures are shown in Figure 9. It appears that the share of households that had to use drastic measures to meet health expenditures has declined between 2000 and 2003. Smaller share of households indicated that they had to borrow money, reduce consumption, or ask help from relatives. There was not change in the share of households reporting selling animals, or valuables. The only coping mechanism that is on the rise is the use of own savings. This may be explained by the success of hospital based exemption schemes to help the most vulnerable.

In sum, out-of-pocket payments continue to place a sizeable burden on those households that experience a treatment episode at a health facility (outpatient or inpatient). This financial burden is particularly large for low-income households. The poorest quintile spends on average more than 50% of their annual per capita household resources on out-of-pocket payments if they report a visit or hospitalization. The reforms have not yet narrowed this gap in financial protection, and this requires policy attention in the next phase.

[5] See WHO-DFID HPAP Policy Research Paper #24 available for download at http://hpap.med.kg

Figure 14. Coping mechanisms among Kyrgyz households to meet health expenditures



Source: HBS-2001; KIHS-2004

6 Lessons learnt

As chapter 5 demonstrated, the Kyrgyz health financing reforms have contributed to greater efficiency, better quality, improved transparency and more equal access to health care services. These are great achievements indicating that the health financing system and its components are working to the intended direction. This is largely due to the sophisticated pooling and purchasing arrangements with a wide-range of incentives aligned to promote efficiency, quality and equity.

At the same time, funding for the health system has been critically low and unpredictable over the time-period of reform implementation. This has led to several problems for the operation and credibility of the health system and also undermined the ability of health financing reforms to mitigate the financial burden associated with seeking care, particularly for the poor. It would be inappropriate to conclude that the reforms themselves are to blame to for this outcome in our view. If public funding decline, greater burden falls on the population regardless of what kind of system of financing is in place. This outcome would have occurred under the old health financing system as well as it in fact did occur in the early 1990s. As public funds drastically declined, informal payments became increasingly wide-spread. Thus, it would be a mistake to roll back the single-payer system and the co-payment policy in the hope of improving financial protection. Given adequate funding, further fine-tuning of the targeting mechanisms and a review of the pharmaceutical pricing policy would lead to demonstrable effects on financial/risk protection.

The key lessons learnt in the implementation of these reforms are as follows.

The successes of the Kyrgyz health reform are in part due to focusing on a comprehensive approach rather than on isolated instruments. The Kyrgyz reforms were not attempting to find the magic bullet to improve all health system objectives by implementing the “right” benefit package, or the “right” provider payment reform, etc. The reforms involved a coordinated package of changes in pooling, purchasing, design of benefit package and patient co-payments. A key element of this package was a carefully structured and well aligned financial incentive system both on the provider and patient side. In addition, reforms of health care financing were complemented with careful harmonization of the organization and structure of service delivery at both the macro and micro levels. This included restructuring of facilities and extension of provider autonomy.

Complex reforms require careful sequencing of various reform steps. The Kyrgyz reforms stand out in this regard. First, it was implicitly acknowledged that without improvement of efficiency through downsizing, other health system objectives such as equity and quality cannot be improved given the fiscal constraints of the country. Through the combination of financing and service delivery reforms, Manas-I was extremely successful in achieving efficiency gains and paved the way for focusing on other health system objectives in the next phase. Second, the reform measures within health financing were also carefully sequenced. Changes in revenue collection and pooling were the initial steps to ensure optimal flow of public funds first. This was followed by introducing new purchasing arrangements that would change the incentives providers faced. These steps created transparency within the public sector. The benefit package/copays were the last step and created a transparent social contract between the population and providers.

The slow pace of reforms in the overall public finance system created a challenging environment for the health sector to operate in and limits its ability to achieve efficiency, quality and equity gains. The health sector gradually but firmly moved away from input-based line-item budgets and administrative control mechanisms and began to adopt performance management and output-based payment of public providers. These

changes have achieved considerable successes in terms of improving transparency and efficiency of public management in the health sector. At the same time, these ideas remained revolutionary within the overall public system which continues to largely operate on the inherited principles of input based budgeting and strict line-items. This mismatch between the pace of the public finance reform and health finance reform has created significant problems for the health sector in the annual budget negotiation process.

Progress on efficiency and quality would have been much more difficult had the MHIF not been formed as a para-statal agency in charge of purchasing. The Single Payer system has successfully adopted "strategic purchasing" into its day-to-day operations. This has included the introduction of output based payment mechanisms, cleverly structured incentives for referrals and exemptions, the Additional Drug Package and regular monitoring of quality. All these tools have provided explicit incentives for efficient and high quality provision of health care. This has led to documented improvements in efficiency of service delivery. If the MHIF had not been set up outside the core public sector, it would not be able to purchase services "strategically" and would have to return to the use of hierarchical line-item input control. This type of input-based budgeting was a major source of inefficiency in the system inherited from the USSR and could not have overcome without completely changing purchasing methods.

7 Policy recommendations for Manas-II

Based on analysis in this paper, we suggest 4 key areas of focus in health financing for the next phase of Manas-II.

First, a critical task for the coming time-period is to focus on improving financial protection in health financing. The first phase of health reforms has been successful in increasing transparency in the system and improving efficiency. These improvements have tangible benefits such as better patient care (available drugs and supplies, better equipment, modernized facilities, and warmer hospitals) and higher salaries for doctors. However, the financial burden of seeking care continues to place a high burden on Kyrgyz households, in particular on the poor. Improving financial protection is critically important from a poverty reduction perspective. In addition, this step would help increase population satisfaction with the health reforms. We recommend the following mechanisms for consideration:

- It is important **not to roll back the single payer reform and the co-payment policy** in the hope that this would improve financial protection. As discussed above, it is not the system or its components responsible for this outcome but in many respects the low level of public funding. Rolling back the implemented health financing reforms would in fact not improve financial protection as informal payments would return, and would lead to loss of transparency and decline in efficiency and quality.

- The most effective instrument to improve financial protection in the Kyrgyz context is to gradually reduce formal out-of-pocket payments across the board for all hospital admissions and replaced them with public funding. This is in contrast to other possible recommendations such as putting in place a tighter exemption mechanism. In our view, in Kyrgyzstan where 50% of the population is poor, an exemption mechanism would face significant targeting difficulty and the cost of administering the system may not be worth its benefits. Thus, increased public funding and lower co-payment would go a long way in reducing the financial burden of illness for the poor.

- Finally, as we demonstrated pharmaceutical consumption is driving the growth of out-of-pocket payments. Revising pharmaceutical pricing practices and rational drug use is an essential next step during the next phase of the reforms.

Second, a precondition to achieve better financial protection is to ensure increased and stable public funding for the health sector. We recommend the following improvements in order to achieve this:

- Carry planned health expenditure levels in the MTBF to the annual budget process that forecast increasing shares and levels of public resources to the health sector

- Move to defining allocations for vulnerable categories to per capita basis

- Move to calculation on a per capita basis using the SGBP as the benchmark with adjustments for populations at health risk and rural and high mountain areas.

- Improve overall budget execution level, and in particular budget execution for vulnerable groups and reduce reliance on sequestration as a means of expenditure control.

- Continue to maintain the improved rate of transfers from the SF to the MHIF.

Third, a further challenge is the harmonization of the SP system with the fiscally decentralized public finance system. Box 2 below summarizes the three key options

proposed in Kyrgyzstan in early 2005. Although these options are currently in a state of flux, the principles we highlight in our analysis will apply to a wide range of potential options. Based on the earlier proposed 3 options, our position is that optimal gaol attainment would be possible by a national single-payer purchasing pool managed by the MHIF for services included in the SGBP and a strengthened MOH setting policy direction to guide the MHIF's purchasing activities. Both option 1 and 2 would greatly damage health financing objectives reviewed in this paper and would set back the Kyrgyz health financing system by 10 years.

Box 2. Fiscal decentralization and health care financing

The Kyrgyz Republic, as many CIS countries, is embarking on fiscal decentralization. This process presents some unique challenges for the health system. Health financing, unlike many other social sector programs, requires pooling of risks across large populations for optimal effect on both efficiency and equity. This large population risk-pooling, however, is at odds with fiscal decentralization which aims to transfer responsibility and funding for a wide range of services to small administrative levels.

In the fall of 2004, a law on fiscal decentralization was passed. The law implies that starting from 2006, the budget of the Kyrgyz Republic will be composed of two parts: (i) budgets of local self-governments (Ayil Okmotus + cities with elected self-governments); and (ii) Republican-Oblast-Rayon budget all pooled at the national level.

This law is at odds with the current health financing system. As described above, the Kyrgyz Single Payer System receives most of its revenues from oblast and sub-oblast level taxes. These taxes are then transferred to oblast level purchasing pools under the MHIF. Under the new decentralization law, these administrative levels will not form their own budget but will be part of the larger Republican budget. Thus the current institutional structure and flow of funds is not an option for the health sector beyond 2005.

In order to harmonize the Kyrgyz health financing system with the decentralized fiscal system, three options have been proposed.

- **Option 1**: Full decentralization whereby each *ayil okmotu* pools state budget funds and purchases services from local providers; MHIF pools only payroll tax revenue (7% of total health expenditures) and purchases only for insured
- **Option 2**: MOH budget department pools all state budget funds and purchases services; MHIF pools only payroll tax revenue (7% of total health expenditures) and purchases only for the insured
- **Option 3**: Extension of the Single Payer – MHIF pools state budget funds at Republican level for the entire population and "insurance money" for insured population and hence remains the single purchaser for the entire population

A recent policy paper reviews each of the three options in detail and discusses their strengths and weaknesses. The paper comes out with the conclusion that only option 3 will ensure that previous gains in equity, efficiency and transparency will be maintained. Options 1 and 2 represent a significant departure from the current health financing system, would set back the development of the Kyrgyz health system to the early days of transition, and would lead to the loss of many years of difficult technical and political work as well as to the loss of financial investment of both the Kyrgyz government and the donor community. Options 1 and 2 would have severe negative consequences on equity, efficiency, and transparency of health financing. Given that the current health financing system has delivered major and evidenced improvements in the health system, the authors strongly urge against a major departure from the current principles on which the health financing system is founded. These principles are best embodied in Option 3. (See Kutzin, O'Dougherty, Jakab. 2005. "Fiscal decentralization and the Kyrgyz health financing system: reflections on three options" WHO-DFID HPAP Policy Research Paper #28. Bishkek, Kyrgyz Republic)

Fourth, strengthening the MTBF process would provide a great tool to better harmonize public spending with medium-term policy priorities. This requires the following steps:

- Greater transparency by the MOF on the calculation of health sector ceilings and how this meets the policy prioroities of the Government

- Greater attention by the MOH to identifying policy priorities in the health sector and some rules for determining how allocations will be made in the case of a gap between needs and provided budgets, i.e, which policy priorities will be funded, at what levels and why? What will be the strategy for financing programs that are not fully covered.

- Further capacity building and a joint work program for implementation between MOF and MOH.