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Analysis of the Medium-Term Financial Sustainability of the State Guaranteed Benefits Package

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1. Introduction

The State Guaranteed Benefits Package (SGBP) regulates the entitlements of Kyrgyz citizens to medical services. The SGBP was introduced in 2000 in order to establish a predictable and transparent system of citizen obligations and rights. Broadly, the SGBP provides for free medical care at the primary care level and for referral care against regulated co-payments. The SGBP and its co-payment levels are revised annually.

The depth of coverage afforded by the SGBP is the result of compromises among competing objectives. On the one hand, there is often pressure on policy makers to increase the depth of the benefit package in order to reduce the financial burden on the population and improve access to services. On the other hand, the fiscal realities of the Kyrgyz Republic limit how much the scope of the benefit package can be increased. While the depth of the benefit package can be increased easily by an act of legislation, it will not result in improved financial protection if it is not accompanied by an increase in funding. It has been demonstrated that co-payment revenues contribute to the funding of medicines and medical supplies at the hospital level. Reduction of co-payment revenues without an increase in public funding is likely to lead to an increase in informal payments.

In 2006, large-scale changes were introduced to the entitlement structure of the SGPB significantly increasing the depth of coverage. Co-payments were eliminated for all deliveries, for children between the ages of 1-5 and for pensioner 75 years or older. This expansion of the SGBP took place at the same time as the first year of the implementation of Manas Taalimi supported through a Sector Wide Approach (SWAp) with increased funding allocated to the health sector and specifically to the SGBP both from the government and the donors (through budget support). While the expansion of the SGBP was a welcome move on financial protection and equity grounds, concerns were raised whether the injection of additional financing was sufficient to cover the revenue shortfall due to the expansion of entitlements.

The purpose of this paper is to provide an analysis of the impact of the recent changes in co-payment policies on the medium-term financial sustainability of the State Guaranteed Benefits Package. The analysis compares the funding needs of the SGBP (estimated costs) with the funding available from the budget (including funds of Joint Financiers) and co-payments and estimates a funding gap. The impact of changes in the co-payment policy is estimated on the funding gap. The paper finds that the reduction of co-payment revenues did not have an adverse effect on the financial sustainability of the SGBP due to a substantial increase in the level of public financing for the program. In other words, the expansion of the SGBP was revenue neutral for the program as it was accompanied by a commensurate increase in public funding. However, a funding gap existed before the expansion of the SGBP and even with highly optimistic assumptions about economic performance of the country and government commitment to the health sector, only 77 to 80% of the costs of the SGBP are actually funded by the state budget. Hence, further expansion in the SGBP is not recommended until this funding gap is closed.

The paper is structured as follows. Section 2 defines the State Guaranteed Benefits Package and describes the methodology for estimating its financing needs. Section 3 discusses the funding gap in the SGBP prior to the expansion of entitlements. Section 4 examines in detail the impact of lowered co-payments on utilization (4.1) on co-payment collections (4.2), on short- and medium-term funding gap (4.3 and 4.4). Section 5 summarizes key findings and recommendations for future research.

2. How are the funding needs of the SGBP estimated?

The State Guaranteed Benefits Package (SGBP) regulates the entitlements of Kyrgyz citizens to medical services. The SGBP provides free PHC services for all citizens, regardless of their insurance status and enrolment status with a primary care provider. Certain lab and diagnostic tests are provided against co-payment. Referral care for outpatient specialist care and hospital care is provided against co-payment with the exception of certain exempt categories. Co-payment is a flat fee payable upon admission. It varies with insurance status, exemption status, case type (delivery, surgery, medicine), and whether the patient has a written referral from primary health care physician. Exemption categories were designed based on categorical targeting and disease types to protect populations with high expected health care use. Providers receive a higher payment for treating exempt patients to prevent selection.

The methodology for estimating financing needs for the SGBP was developed and officially adopted in 2005 (Government Decree # 280, July 1, 2005). The methodology, with the exception of emergency care, is based on the available financing and not on an actual estimate of the costs of delivering the services.[1] Its main purpose is to equalize funding across the regions for the same type of services. Also, the existing reimbursement rates are not directly linked to these estimates. Thus, any analyses of the financial sustainability of the SGBP will be constrained by this factor. Due to the specific nature of each type of care (emergency, dental, FMC, FGP, hospital, drugs at outpatient level for certain disease categories) costing methodology for each one of them is different.

2.1. Costing of hospital care

Costs for hospital care under the SGBP are estimated through the following six steps:

1. For each oblast, calculate the government budget expenditures per case on the basis of the 2005 approved budget for hospital care.

2. Take out the expenditures for high altitude and rural coefficients from per case expenditures.

3. Classify expenditures into the following categories: salaries, food and medicine, and other.

4. As the main aim of the SGBP policy at hospital level is to equalize expenditures across regions for food and medicine, expenditures for these items are brought up to the level of Bishkek, which is the only region that follows the norms for food and drugs supply, in all oblasts. These are the "needs" for food and medicine under the SGBP and form part of the total cost of the SGBP.

5. Thus, the total cost of the SGBP is the approved state budget expenditures on salaries and other items and "normative" expenditures for food and medicine.

6. These newly estimated expenditures per case are multiplied by the number of patients, which is then divided by the population in order to get per capita costs of hospital care under the SGBP.

[1] The description of the costing methodology is based on Socium Consult, 18 May 2007 “Modeling the level of financing of SGBP – Kyrgyzstan”. Authors would like to acknowledge a special contribution made by Asel Ryskeldieva from Socium Consult to the writing of this section.

2.2. Costing of primary health care

Costs for PHC under the SGBP are estimated through the following five steps:

1. For each oblast, divide the total government budget expenditures for primary care by the population to get per capita expenditures.

2. Take out the expenditures for high altitude and rural coefficients from these expenditures.

3. As the main aim of the SGBP policy at PHC is to equalize salaries for health workers, expenditures for this item are brought up to the oblast with the highest salary salary level, which is surprisingly not Bishkek but Talass. These are the "needs" for salaries under the SGBP and form part of the total cost of the SGBP.

4. Based on the analysis on PHC expenditures, it was determined that the share of salaries in total budget expenditures at PHC level should not exceed 70%. However, in reality in many oblasts in 2005, 85% to 95% of expenditures from the budget went for salaries. Thus, for each oblast PHC expenditures for items other than salaries are raised proportionately to the level needed to ensure that the share of salaries there does not exceed 70%.

5. The sum of newly estimated expenditures on salaries and actual expenditures for other items is multiplied by the number of people.

2.3. Costing of emergency care

Costs for emergency care under the SGBP are estimated through the following seven steps:

1. Average budget expenditures per one visit based on following norms and assumptions: average radius for driving is 15 km, fuel consumption is 15 lt. per 100 km, average cost of one lt. of fuel is 17 soms, increase in the level of maintenance costs of ambulance car is 10%, three medical workers per team, average monthly salary of the team, minimum expenditures on drugs and medical supplies per 1 visit is 11 soms;

2. Normative number of visits per year is determined by the MOH prikaz;

3. Minimum standard of budget financing of one general emergency team for 2005 is 103 447 KGS;

4. There are special coefficients for (i) specialized and (ii) stand-alone emergency teams;

5. Total number of emergency teams is based on the official report on emergency care for the previous year;

6. Total number of general emergency teams is multiplied by the estimated minimum cost of one general emergency care team and the same is done for specialized and stand-alone teams; and

7. Total cost for all types of emergency teams is divided by the total population.

The SGBP is financed not only through the state budget but also through several other sources and together they cover a significant share of the Program's expenditures. These sources include the following: (1) MHI funds for the employed collected by the SF and transferred to the MHIF, (2) MHI funds for the vulnerable groups transferred to the MHIF from the Republican budget, (3) Republican and local budget special means, and (4) Co-payments. To calculate the per capita cost of the SGBP financed by the MHI funds for the employed, special means and co-payments, actual total expenditures by each of these three sources are divided by the population.

To estimate the financing requirements from the MHI funds for the vulnerable groups first, the total health insurance funds for the employed are divided by the number of the insured; second, the estimated cost per insured is multiplied by the total number of people in the vulnerable groups whose insurance is paid by the Republican budget. This is considered to be the actual cost of the SGBP that should be covered by the insurance, although the Republican budget transfers per insured are significantly lower as they are based on the available budget. The estimated sum is divided by the population, which gives the per capita cost of the SGBP that is to be financed by the Republican budget transfers for vulnerable groups.

The per capita costs of the SGBP for each type of service are multiplied by the total population, which is then multiplied by relevant coefficients. As the final step, the total costs for each type of service are summed together, which gives the total costs of the SGBP at the baseline.

The method for medium-term projection of the cost of SGBP is as follows: The baseline (2005) value of the per capita cost of the SGBP is first divided by sources of financing and then, into salaries and other expenditures. The value for salaries financed by the state budget is multiplied by a coefficient for the annual salary raise for health workers. It should be noted here that salaries of public servants, including health workers, have grown and are expected to grow at 20%, although in 2007, they have been raised by 30%. The value for salaries financed through all other sources (special means, MHIF contributions and co-payments) and the value for other expenditures (including those financed by the state budget) are multiplied by the inflation rate. To get the total cost of the SGBP for each type of service, the sum of the two values (salaries and other expenditures) is multiplied by the total population, which is expected to grow by 1% over the next 3 years. The costs for all types of services that are part of the SGBP are summed together to get the total cost of the program. **Table 1** demonstrates the process through the example of calculating the SGBP costs for 2006.

3. Funding gap for the SGBP prior to expansion of entitlements

The costing methodology described above was to be applied only for the allocation of resources within the sector and gradual equalization among the regions. The overall health sector budget was still determined by the MOF based on historical trends and general level of public expenditures. Thus, from the very start there has been a **significant funding gap** for the SGBP (see **Table 2**). Based on the methodology described above, in 2005 the total cost of the SGBP was 2.5 billion KGS (Socium Consult, 18 May 2007 "Modeling the level of financing of SGBP – Kyrgyzstan"). The actual financing for the Program was 1.8 billion KGS, including co-payments, which resulted in the coverage gap of 27.4%.

Table 2: Funding gap, 2005 (thous. KGS)

	2005
Costs of the SGBP	2 498 265
Expenditures on SGBP (State budget, SF)	1 595 001
SGBP Coverage (1)	**63,8%**
Co-payment	219 400
SGBP Coverage (2)	**72,6%**

Source: Socium Consult, 18 May 2007. "Modeling the level of financing of SGBP – Kyrgyzstan"; MOH, 2006. *FMR 2005.*

Under-funding of the SGBP contributed to the persistence of informal payments and undermined the key goals of the introduction of the SGBP – clear definition of rights and responsibilities of patients and the state with regard to provision of health services and clarification of entitlements for different population groups. However, regardless of the existing funding gap there was a growing pressure from the national parliament and a few interest groups to reduce or eliminate co-payments.

4. Impact of expanding the depth of the SGBP

In 2006, with a small increase in state budget financing and additional grant-based support from several large donors, the Government broadened the exemption categories for co-payments under the SGBP, raising questions about its financial sustainability. According to the 2006 Government Decree on State Guaranteed Benefits Program the following groups, in addition to the already existing ones, were exempt from any co-payments:

- Children between the ages of 1 and 5 years old (children under 1 had been exempted previously),
- Pregnant women who have registered as such and women who have given birth during the past eight weeks, and
- Elderly at the age of 75 and older.

In addition, co-payments during hospitalization for pensioners under 75 were reduced to a minimum level.

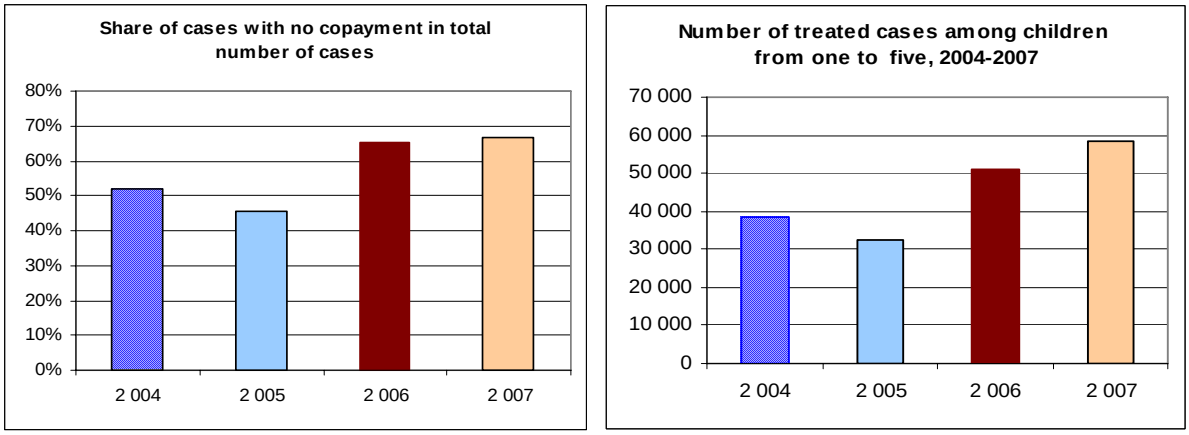
In this section, we examine the impact of the policy on utilization of hospital services among the exempt groups (4.1), its impact on copayment collections (4.2) and on short- and medium-term funding gap (4.3 and 4.4).

4.1. Impact on utilization

The decrease in prices as expressed through the reduced co-payment rates led to increase in demand. Thus, from 2005 to 2006, there is a sharp increase in the total number of hospitalizations among the newly exempt groups. The total number of hospitalizations increased from 681,320 to 756,274 or 11% (MHIF Clinical Information Forms Database, September 2007). The percentage increase among the newly exempt groups was significantly larger. For instance, the number of hospitalized cases among children from one to five increased by 57.5% and among pensioners older than 75 by 28.4% (MHIF Clinical Information Forms Database, September 2007). Overall, these trends led to a marked increase in the share of exempt patients in total number of cases from 45.6% to 65.2% (**Figure 1**).

In 2007, according to projections based on the trend for the first six months the expected number of cases will increase only slightly, by approximately 5.8%. Moreover, the share of exempt patients in total number of cases is expected to stay approximately the same as in 2006. The number of cases among children from one to five is expected to grow only by 14.5% (**Figure 1**).

Figure 1: The share of exempt groups in total number of cases and number of treated cases among children under five, 2004 - 2007



Source: MHIF Clinical Information Forms Database, September 2007.

Thus, it seems that the initial rise in demand following the lowering of co-payment rates is leveling off, which is consistent with experience from other developing countries with either increasing or decreasing of user fees. The share of cases with no co-payments is expected to stay around 65% and not to exceed 70%.

4.2. Impact on co-payment collections

As a result of increased share of exempt patients, the total amount of co-payments collected by hospitals decreased from 219,400 thousand KGS in 2005 to 182,900 thousand KGS in 2006, or by 11% in real terms.[2] As **Table 3** shows, following the introduction of the new copayment policies, the volume of copayments collected from the newly exempt categories decreased by 90%, or approximately 38.48 mln KGS. The increase in the volume of copayments for all other categories of patients, including those who have been exempt previously, was only 1.1%, or approximately 1.95 mln KGS. This clearly was not enough to offset the loss that resulted from new exemptions, which led to a 16.6% (or 11% in real term) decline in the volume of copayments collected in 2006, which equals to 36.53 mln KGS.

Table 3: Changes in volume of copayments by the exemption category, 2005 – 2006 (KGS)

	2005	2006	% change 2005-06
Co-payment for deliveries	19 173 840	2 180 138	-88,6
Co-payment from children one to five years of age	18 578 592	1 364 634	-92,7
Co-payment from pensioners older than 75	4 978 033	707 847	-85,8
Total co-payment from newly exempt groups	42 730 465	4 252 619	-90,0
Co-payment from all other categories	176 669 535	178 620 181	1,1
Total co-payment collections	219 400 000	182 872 800	-16,6

Source: MHIF Clinical Information Forms Database, November 2007; MOH, 2006. *FMR 2005*; MOH, 2007. *FMR 2006*.

[2] All percentage changes are given in real terms where 2006 CPI to previous year equals 5.7%, which is an official CPI rate given in the Republican Budget Law accessed on May 10, 2007 at http://www.minfin.kg/modules/smartsection/item.php?itemid=679

4.3. Impact on funding gap: short-term

From 2005 to 2006, public expenditures for the SGBP, including the state budget and health insurance contributions to the Social Fund, grew from about 1.6 billion to 1.9 billion KGS, or by 15%. In addition to these domestic resources, there was an increase in funding for the SGBP through external financing (234.6 million KGS). The total increase in funding for the Package between 2005 and 2006 was 29%, which allowed increasing its coverage from 72.6% to 83.6%, despite the decrease in total co-payments and increase in number of cases (see **Table 4**). There are however, still questions regarding the medium and long term future of the current SGBP, particularly with cessation of the external financing in 2010.

Table 4: Short term impact on funding gap of new co-payment policy (thous. KGS)

	2005	2006
Costs of the SGBP	2 498 265	2 800 991
Expenditures on SGBP (state budget and Social Fund transfers)	1 595 001	1 924 184
SGBP Coverage (1)	**63,8%**	**68,7%**
Co-payment	219 400	182 900
SGBP Coverage (2)	**72,6%**	**75,2%**
SWAp funds for SGBP		234 571
SGBP Coverage (3)		**83,6%**

Source: Socium Consult, 18 May 2007. "Modeling the level of financing of SGBP – Kyrgyzstan"; MOH, 2006. *FMR 2005*; MOH, 2007. *FMR 2006*.

4.4. Impact on funding gap: medium-term

This section describes in detail projections of the financing sources of the SGBP that are necessary in order to examine financial sustainability of the current SGBP in medium-term.

Total state expenditures are calculated on the basis of GDP figures and share of state expenditures in GDP provided in draft MTBF 2008 – 2010, July 2007 version. Originally, the intention was to use the Country Development Strategy. However, it became clear that the Strategy had overly optimistic projections: For example, it projected 8% real GDP growth for the period of 2007 – 2010, which was questionable given the performance of the country's economy during previous three years. Moreover, already MTBF for 2007-2009 predicted a lower growth rate of around 6% (MOF, MTBF 2007 – 2009, p. 93). Thus, although the MTBF 2008 – 2010 is still a draft it is considered to be the most appropriate document to use for macroeconomic projections.

Total health expenditures are calculated on the basis of the legal agreement between the Government of the Kyrgyz Republic and the Joint Financiers providing financial support to the Manas Taalimi Program through the state budget. According to the agreement, the share of total state budget expenditures for health in total state budget expenditures should increase annually and reach 13% by 2010. Projections of the external financing for SGBP, or so called SWAp funds, are also based on the legal agreement between the GOK and Joint Financiers: Given the annual level of funding from the donors and the spirit of the Manas Taalimi Program on ensuring equity and financial protection when accessing basic health services, a large share of the SWAp funds are targeted to improving quality and financial sustainability of the SGBP.

Projections of the Social Fund transfers to the MHIF assume that regardless of changes in social tax rate, the health insurance contribution rate will stay at 2%. Calculations are based on the SF projections of the total wage bill, which is expected to grow at the same rate

as the GDP. For example, if in 2006, the total wage bill was 18.2 billion KGS, then in 2007, it is expected to be 20.4 billion KGS, which is about 12% growth rate - 6.5% GDP growth rate and 5.6% inflation rate (draft MTBF 2008 – 2010).

On the basis of the 2006 and 2007 official budget figures for the MHIF contributions from the SF, the share of MHIF contributions in the total wage bill is calculated. Their average (1.7%) is assumed to stay constant until 2010. In theory, it should be 2% of the total wage bill. However, the collection rate is about 87% of the total amount of social contributions because not all employers pay on time or pay at all, and the MHIF contributions are calculated as 2% of the actual amount collected as social contributions. Thus, the actual social contributions equal social tax rate divided by 100, multiplied by the total wage bill, which is then multiplied by the collection rate divided by 100. Also, according to existing regulations, SF takes 3% of the MHIF contributions for administrative expenditures.

In 2007, **co-payments** are expected to further decline since the population awareness of the new co-payment policy has improved since its initiation in 2006 when, as evidenced by the Clinical Information Database, some facilities continued charging co-payments from newly exempt patient groups. From 2007 to 2010, assuming that there will be no further changes in co-payment policies and no significant changes in the socio-demographic and disease characteristics of the country's population such as a large increase in the number of children under five or decline in the number of patients with disease categories that are eligible for exemptions, co-payments are projected to grow by the inflation rate (5%).

Based on these assumptions and figures, SGBP coverage is projected to gradually increase between 2005 and 2010, reaching 78%, without considering the available external funding (**Table 5**). However, the decline in funding gap is mainly due to the increase in public expenditures, including contributions to the Social Fund, which are growing and are expected to continue to grow on average at the rate of 17% per year between 2007 and 2010. This is likely to be an optimistic projection: It is based on the optimistic projections regarding (i) GDP growth rate which assumes that the average real growth rate between 2008 – 2010 will be 7.2%, (ii) state budget expenditures which are inevitably overestimated if the GDP is not projected accurately as they are estimated as a share of GDP, (iii) health sector expenditures as it is assumed here that the Government will fulfill its financial obligation under the Manas Taalimi Program.

It is interesting to note that if we take the 2005 level of co-payments, that is prior to new exemption policy, and using the same approach as above, set its growth rate at 5% per year, which is the same as the expected annual inflation rate, the funding gap does not change significantly, reaching 20.5% by 2010 as compared to the expected 22% given the new exemptions (**Table 6**).

Thus, the 2006 co-payment policy changes do not have a significant impact on the medium-term financial sustainability of the current SGBP. However, at the same time, the analysis shows that even with highly optimistic assumptions about economic performance of the country and government commitment to the health sector, only 77 to 80% of the costs of the SGBP are actually funded by the state budget. Hence, it is clear that future attempts to broaden the SGBP and introduce further exemptions to co-payments should be carefully examined as they will increase the funding gap, further undermining the financial sustainability of the Package.

5. Conclusions

As stated in the first section of the paper, the main objective of the SGBP is to promote transparency in the entitlements and obligations of the population. It is a promise: the Government guarantees to its citizens that they are entitled to certain set of basic health care services if they follow certain rules, including following the system of referrals, paying social taxes, and making co-payments. Thus, the question about the financial sustainability of the SGBP becomes a question about how well can the state sustain the credibility of this promise.

Our analysis suggests that the SGBP was not fully funded prior to increasing the scope of the benefit package. In 2005, the available funding covered 72.6% of the estimated financing needs of the SGBP. The co-payment exemptions introduced in 2006 did not affect adversely the financial sustainability of the SGBP. The increase in public funding was greater than the loss of co-payment revenues slightly increasing the coverage of the SGBP to 75.2%. The persistence of a funding gap for the SGBP suggests that increased public funding ought to be targeted to covering the funding gap before further coverage expansion is considered. Without changes in the current entitlements, the planned increase in public expenditures (at the average rate of 17% per year between 2007 and 2010) will only raise coverage of the SGBP to 78%.

This paper has considered the impact of co-payment reductions from the perspective of financial sustainability for the SGBP. There are additional factors, however, that need to be analyzed in order to make a comprehensive assessment of the impact of co-payment reduction on access and household financial burden. While utilization has increased, it will be important to analyze the distributional aspect of utilization using household survey data to understand whether the poor have equally benefited from the reduction of co-payments as the non-poor. The 2007 Health Module of the Kyrgyz Integrated Household Survey will provide an opportunity to address this question. Second, there is a danger that the lowering of co-payments has led to an increase in informal out-of-pocket payments thus, undermining the purpose of the SGBP. The 2007 Discharged Patient Survey will provide an opportunity to analyze this question. Thus, the results of this analysis need to be supplemented by a study based on the two survey results in order to be able to draw more definite conclusions.

Table 1: Cost of the SGBP, 2005 – 2006

	Total	*including:*						
		Ambulance	Dental	FMC	FGP	Hospitals	Other	Drugs
2005								
Population size	**5 138 700**	5 138 700	5 138 700	5 138 700	5 138 700	5 138 700	5 138 700	5 138 700
High altitude coefficient		1,0325	1,0325	1,0325	1,0325	1,0325	1,0006	1,0325
Rural coefficient		1,0472	1,0486	1,0551	1,1220	1,0556	1,0000	1,0000
Small towns coefficient		1,0449	1,0371	1,0324	1,0137	1,0321	1,0000	1,0000
Minimum standard financing (soms per capita)	**427,8**	**17,6**	**17,6**	**48,7**	**117,2**	**217,6**	**1,7**	**7,3**
budget	**300,5**	16,9	13,0	47,2	60,8	153,6	1,6	7,3
MHI from the RB transfers	**41,4**	0,0	0,0	0,0	28,1	13,4	0,0	0,0
MHI from the SF	**41,4**	0,0	0,0	0,0	28,1	13,4	0,0	0,0
copayments	**38,5**	0,0	2,2	0,7	0,0	35,7	0,0	0,0
special means	**5,9**	0,7	2,4	0,8	0,3	1,6	0,1	0,0
Needs according to the min standards (thous. soms)	**2 498 264,8**	**102 132,0**	**101 452,4**	**281 698,3**	**707 517,8**	**1 258 019,8**	**8 844,3**	**38 600,2**
state budget	**1 747 902,1**	97 883,7	75 048,5	272 896,6	367 041,2	887 983,7	8 448,3	38 600,2
MHI fro the republican budget	**246 600,0**	0,0	0,0	0,0	169 309,4	77 290,6	0,0	0,0
MHI from the SF	**246 600,0**	0,0	0,0	0,0	169 309,4	77 290,6	0,0	0,0
copayments	**222 793,7**	0,0	12 470,6	4 157,2	0,0	206 165,9	0,0	0,0
special means	**34 368,9**	4 248,3	13 933,3	4 644,4	1 857,8	9 289,0	396,0	0,0
2006								
Population size	**5 190 087**	5 190 087	5 190 087	5 190 087	5 190 087	5 190 087	5 190 087	5 190 087
High altitude coefficient		1,0325	1,0325	1,0325	1,0325	1,0325	1,0006	1,0325
Rural coefficient		1,0472	1,0486	1,0551	1,1220	1,0556	1,0000	1,0000
Small towns coefficient		1,0449	1,0371	1,0324	1,0137	1,0321	1,0000	1,0000
Minimum standard financing (soms per capita)	**479,4**	**19,2**	**19,1**	**54,4**	**135,6**	**241,4**	**1,9**	**7,7**
budget	**333,0**	18,5	14,3	52,8	68,0	169,9	1,8	7,7
MHI from the RB transfers	**49,7**	0,0	0,0	0,0	33,7	16,0	0,0	0,0
MHI from the SF	**49,7**	0,0	0,0	0,0	33,7	16,0	0,0	0,0
copayments	**40,7**	0,0	2,3	0,8	0,0	37,7	0,0	0,0
special means	**6,3**	0,8	2,5	0,8	0,3	1,7	0,1	0,0
Needs according to the min standards (thous. soms)	**2 800 990,5**	**111 630,0**	**110 413,6**	**314 345,9**	**818 593,1**	**1 395 345,7**	**9 900,5**	**40 761,8**
state budget	**1 937 586,7**	107 143,8	82 531,0	305 051,3	410 288,7	982 327,8	9 482,3	40 761,8
MHI fro the republican budget	**295 920,0**	0,0	0,0	0,0	203 171,3	92 748,8	0,0	0,0
MHI from the SF	**295 920,0**	0,0	0,0	0,0	203 171,3	92 748,8	0,0	0,0
copayments	**235 270,1**	0,0	13 168,9	4 390,0	0,0	217 711,2	0,0	0,0
special means	**36 293,6**	4 486,2	14 713,6	4 904,5	1 961,8	9 809,2	418,2	0,0

Source: 2005 population figure – NSC, Annual Demographic Bulletin 2001-2005, Bishkek 2006; Socium Consult, 18 May 2007. "Modeling the level of financing of SGBP – Kyrgyzstan".

Table 5: SGBP funding gap projections, 2005 – 2010 (thous. KGS)

	2005	2006	2007	2008	2009	2010
Costs of the SGBP Socium Model	2 498 265	2 800 991	3 198 283	3 801 661	4 294 787	4 864 417
Expenditures on SGBP, including State budget & SF transfers for health insurance	1 595 001	1 924 184	2 294 314	2 783 173	3 203 629	3 587 177
SGBP Coverage (1)	**63,8%**	**68,7%**	**71,7%**	**73,2%**	**74,6%**	**73,7%**
Co-payment	219 400	182 900	180 000	189 000	198 450	208 373
SGBP Coverage (2)	**72,6%**	**75,2%**	**77,4%**	**78,2%**	**79,2%**	**78,0%**
SWAp funds for SGBP		234 571	304 571,1	346 500,0	346 500,0	346 500,0
SGBP Coverage (3)		**83,6%**	**86,9%**	**87,3%**	**87,3%**	**85,1%**

Source: Socium Consult, "Modeling the level of financing of SGBP – Kyrgyzstan", 18 May 2007; SF Report 2005, 2006; MOH, 2006. *FMR 2005*; MOH, 2007. *FMR 2006*; 2007 Approved Law on Republican Budget; MOF Note on salary raise for the health sector and MHIF internal note on the share of salary raise that is planned for SGBP; WB Planned disbursements 2007-2010, email from May 30, 2007; MTBF 2008 – 2010.

Table 6: SGBP funding gap projections without changes in co-payment policies, 2005 – 2010 (thous. KGS)

	2005	2006	2007	2008	2009	2010
Costs of the SGBP Socium Model	2 498 265	2 800 991	3 198 283	3 801 661	4 294 787	4 864 417
Expenditures on SGBP, including State budget & SF transfers for health insurance	1 595 001	1 924 184	2 294 314	2 783 173	3 203 629	3 587 177
Co-payment if no change in 2006	219 400	230 370	241 889	253 983	266 682	280 016
SGBP Coverage (4)	**72,6%**	**76,9%**	**79,3%**	**79,9%**	**80,8%**	**79,5%**

Source: Socium Consult, "Modeling the level of financing of SGBP – Kyrgyzstan", 18 May 2007; SF Report 2005, 2006; MOH, 2006. *FMR 2005*; MOH, 2007. *FMR 2006*; 2007 Approved Law on Republican Budget; MOF Note on salary raise for the health sector and MHIF internal note on the share of salary raise that is planned for SGBP; WB Planned disbursements 2007-2010, email from May 30, 2007; MTBF 2008 – 2010.