Policy Brief # 10
Evaluating Manas Health Sector Reforms (1996-2005): Focus on Health Financing

This policy brief is a summary of a detailed study evaluating the achievements of health care financing reforms in the framework of the Manas Health Care Reforms (1996-2005).

The purpose of this paper is 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.

1. Why was health financing reform needed?

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

2. Main directions of health financing reforms

In response to these challenges, Kyrgyzstan introduced a systemic reform changing several key aspects of the health system. 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 type and 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.

3. Achievements and challenges

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. The 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. 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 required 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.

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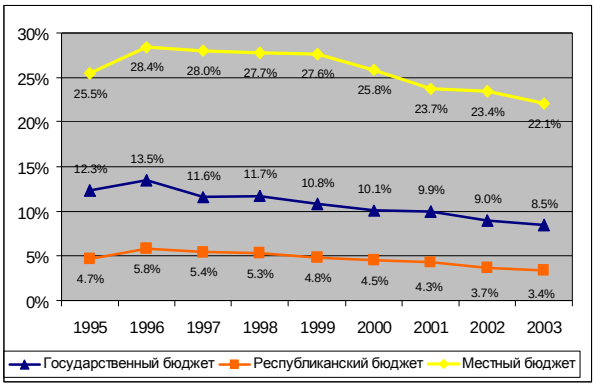
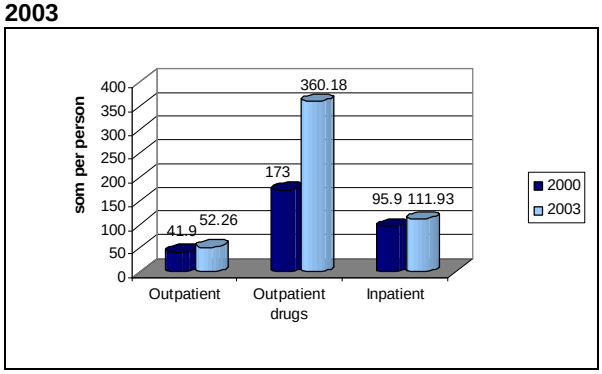
Figure 1. Public expenditures for health as share of the government budget



Source: Treasury, MHIF

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.

Figure 2. Mean out-of-pocket payments in 2000 and 2003



Source: HBS-2001; KIHS-2004

Incentives for efficiency and quality

There are documented improvements in the efficiency and quality of the Kyrgyz health system. 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. 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. (See Policy Brief #6 & #9)

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 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. (See Policy Brief #8)

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 of 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 over the period of 200-2003 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.

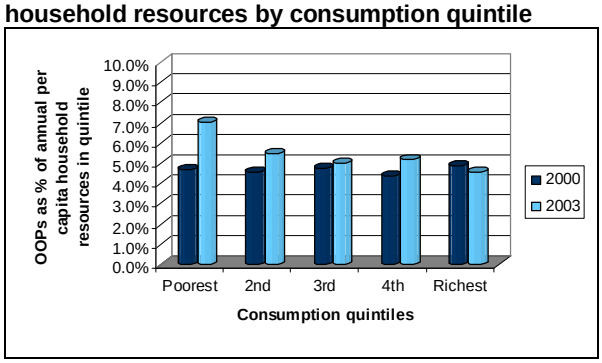
Equity in access to services

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 by the declining utilization of health care among the rich.

Figure 4. Share of out-of-pocket payments in household resources by consumption quintile



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

Several factors drive the increase in out-of-pocket payments and the associated increase in financial burden for the poor.

- First, spending on pharmaceuticals is driving the growth of out-of-pocket payment in all quintiles. 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.
- Third, although our data shows that exemptions reduce the financial burden of illness, exemptions are not targeted to the poor. There are two groups of exemptions: (i) the inherited Soviet categories of war veterans, social pensioners, etc; and (ii) people in certain disability and illness categories (e.g. diabetes, asthma, etc). In the 2004 household survey, the exempt have the same socio-economic status and the non-exempt.

- Fourth, 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.

Our analysis shows, that the key remaining challenge for health financing reform is to mitigate the financial burden of seeking care. In our view, it would be inappropriate to conclude that the reforms themselves have led to the lack of progress in this area. Decline in public funding leads to a greater burden on the population regardless of the system of financing in place. The observed outcome on financial protection 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.

4. 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 of the MHIF under the MOH 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 large 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.

5. Key recommendations for further reforms

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. Since poverty rates in Kyrgyzstan continue to be high, we do not recommend the introduction of a means-tested exemption scheme as the costs of identifying the poor may outweigh the benefits of the policy. An across the board reduction in co-payment and increase in public funding would be a more efficient approach in the near future. 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 to small administrative levels (e.g. Ayil Okmotu) 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. At the same time, decentralization of the management function has the potential to improve quality and responsiveness of service delivery to population needs and expectation. In case of fiscal decentralization, our suggestion is the creation of 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.

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