Policy brief #2
The Kyrgyz Single Payer System

1. What is the Single Payer System?

The Single Payer System is Kyrgyzstan's unique approach to financing and organizing health care services. It was introduced to create a new financial and organizational structure in the Kyrgyz health care system that encourages more efficient and more equitable use of resources.

The law on the Single Payer System provides the following definition: "The Single Payer system integrates financial resources for health care from state budget revenues and mandatory health insurance contributions for the purpose of a single-pipe funding of public health services, curative medical services and pharmaceuticals." (Kyrgyz Law on "Single Payer System in Health Financing in the Kyrgyz Republic" July 30, 2003)

2. Why was the Single Payer System introduced?

Prior to the introduction of the Single Payer System, Kyrgyzstan faced similar problems in its health care system as other transition economies of the Former Soviet Union as well as Central-Eastern Europe:

- **Drastically reduced public funding for health care.** In the early transition period, reduction in public funding available for health care translated into decline in funds for personnel, drug shortages, lacking maintenance of facilities. This created a sizeable funding gap between needed health care services and available resources. It became clear that similar to other transition countries, Kyrgyzstan had to (i) mobilize additional resources in addition to the government budget, and (ii) reduce waste and inefficiency present in the system.

- **Inefficient and unsustainable service delivery system.** The service delivery infrastructure was too large with too many hospital buildings and in some places even too many personnel. Decline in public funds made this inefficiency painfully visible as much of public funds were swallowed by the utility costs and maintenance.

- **Fragmented organization of financing prevented restructuring of health care facilities.** Each government level funded its own facilities: 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. 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.** 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.

- **Inequitable distribution of resources.** Since funding was so decentralized, each level was responsible for finding resources for a relatively small number of people. Poorer areas could raise less resources, and areas with more sick people needed to raise more resources. Funding health care for small populations turns out to be very inequitable in Kyrgyzstan as in many countries because many healthy working people are needed to support the costs of care for a few number of sick people. For this reason, decentralized systems of financing are inequitable and integrating funding sources for larger populations improves equity.

The introduction of the Single Payer System was an attempt to create a new financial and organizational structure in the Kyrgyz health care system that

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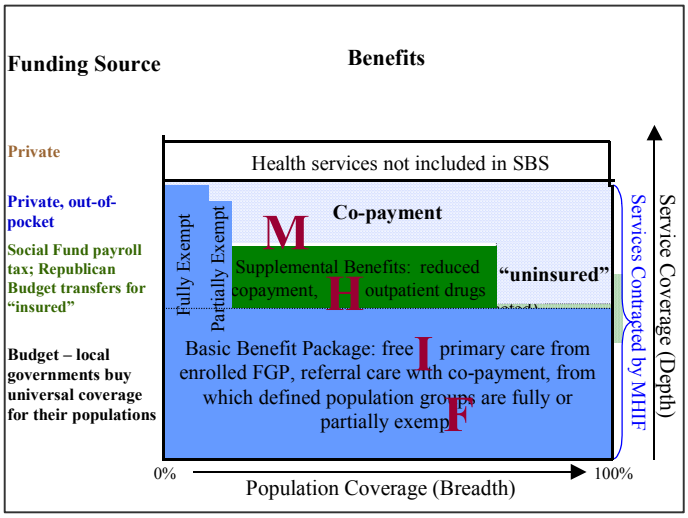
encourages more efficient and more equitable use of resources.

3. What are the key features of the Single Payer System?

- **Pooling of local budgetary 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.

- **State guaranteed basic package for entire population.** These pooled resources fund a basic package of care for the entire population of the oblast. The basic package consists of free primary care, plus referral care to specialists and hospitals with an explicit, formal co-payment. The pooled budget funds also provide for the full costs of care for persons in exempt categories who do not need to pay co-payment.



- **Complementary benefit package for insured population.** In addition to the basic package, insured persons officially enrolled with the MHIF are entitled to a complementary package of care. This consists of a lower co-payment for referral care and access to an outpatient drug benefit. Funding for the complementary package is provided by payroll taxes collected by the Social Fund and transferred to the MHIF, and transfers from the Republican budget to the MHIF.

- **Unified system of purchasing care.** The MHIF and its Territorial departments pay health care providers for the care they render. In primary care, physicians 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, and another copy to the MHIF. Both organizations pay providers based on the same clinical information form, using the same method of payment. Only the source of funds they use to pay is different: the MHIF uses payroll tax revenues collected at the national level and the TDMHIF uses tax revenues collected at the local level.

- **Official patient co-payments.** Patients are responsible for paying (i) for specialist outpatient care both in Family Medicine Centers and Ambulatory-Diagnostic Departments; and (ii) for inpatient care in hospitals. Patients are not supposed to pay anything in addition to this either to doctors or for drugs required for their treatment. (See policy brief #3)

- **Phased step-by-step introduction.** The Single Payer reforms were implemented in a phased manner.
  - 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

4. What are the policy issues and challenges for the Single Payer System?

The Kyrgyz health care reforms began with a significant funding gap between the resources needed to finance health care services and the resources available from budgetary and household resources. In practice, this meant that providers had no resources to purchase drugs and supplies to treat their patients, there was no money to pay for much needed maintenance and renovations, and facilities had difficulties paying their staff. Households were required to make substantial payments when became ill.

Three mechanisms were envisaged to increase funding for the health sector: (i) a small but steady increase in **public** funding for the health sector over the medium-term; (ii) efficiency gains from restructuring retained in the health sector; and (iii) the capturing of informal payments in the form of mandatory formal co-payments. These three mechanisms together were expected to close the funding gap. However, the Kyrgyz health system continues to struggle with sustaining stable funding levels. This undermines the potential of the Single Payer Reforms to improve health and reduce medical impoverishment.

- **Steady decline in public funding places the State Guaranteed Benefit package at financial risk.** The Kyrgyz Government's commitment to the State Guaranteed Benefit Package is based on small and steady increases in public expenditures in the health sector. However, public spending on health care from all public sources (republican budget, local government and categorical grants) has shown a steady decline in recent years. This places the State Guaranteed Benefit Package at risk, is shifting the burden of payment to households leading to the re-introduction of informal payments, and is widening inequities. Decline in public funds also means that providers will yet again face difficulties purchasing drugs and medical supplies for care, paying their staff, and conducting needed renovation. Additionally, reduction in public funds for health is not consistent with the government's commitment to the Comprehensive Development Framework and the National Poverty Reduction Strategy both of which place great emphasis on social sector activities as a corner stone of poverty reduction.

- **Efficiency savings were taken out of the health sector via reduced local budgets and penalize oblasts that have restructured.** Achieving efficiency and productivity gains through restructuring was one of the ways in which the funding gap was going to be filled. In the oblasts where the Single Payer reforms were implemented, restructuring took place indeed: beds were reduced, facilities were closed, non-functional buildings were demolished, duplicated facilities and services have been merged, and non-essential positions have been reduced. This has yielded significant gains in efficiency and productivity. These savings were expected to be re-channeled into higher staff salaries and better quality care including drugs and other medical supplies. This was important in order to ensure that the health sector can continue to function, produce better services, and thus better health for the people. But in many places, oblast allocations for health were reduced. It was argued that because there are fewer beds and fewer staff, the health care system needs fewer resources. But this logic meant that already low salaries and lacking funds for drugs could not be improved through savings and the practice of informal payments will remain to fill the gap.

- **Official co-payments prompted some local governments to reduce public funding.** WHO has conducted several surveys of patient expenditures for hospital care before and after the Single Payer reforms were introduced. (See Policy Brief #3) A most important finding of these surveys was that official co-payments are not a new funding source in the system, they merely replace the previous informal way of paying doctors. Several local governments argued that the health sector now needs less funding because they have co-payment. But this is not so since the co-payments simply formally capture previously unseen and unmonitored forms of payments. If public funds are reduced using this logic, then the practice of informal payment will remain and the quality of health care cannot be improved.