Policy brief #3
Co-payment policy in the Kyrgyz health system

1. What is a co-payment?

- Co-payment is a legally required direct payment made by users of health care services directly to health facilities.

- Co-payments are required (i) for specialist outpatient care both in Family Medicine Centers (FMCs) and Ambulatory-Diagnostic Departments (ADDs); and (ii) for inpatient care in hospitals. 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 (Tables 1a, 1b, and 1c):

  (i) 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
  (ii) Insured patients pay a lower co-payment for referral services (outpatient specialist care and inpatient care) than uninsured patients;
  (iii) Patients without referral pay a higher co-payment than patients with referral

- Some population groups are fully or partially exempt from paying co-payments. Providers receive a higher payment from the MHIF for treating exempted patients. This way, they do not have incentives to favor patients who can afford co-payment. 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.

- The Ministry of Health sets the level of co-payment. The co-payment policy is annually updated.

- Co-payment was introduced in a step-by-step manner matching the pace of the single payer reforms.

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

Table 1a. Co-payment rates for admissions with diagnosis and treatment only (2004)

	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

Table 1b. Co-payment rates for admissions with surgery (2004)

	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

Table 1c. Co-payment rates for admissions less costly surgery (2004)

	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

2. Why was co-payment introduced?

- **Co-payment was introduced to transform the already existing informal payments made to doctors into official and transparent payments as part of the overall health sector resource mobilization strategy.** Direct payments by patients to doctors were not new in the Kyrgyz health care system. Patients have been paying doctors informally and paying for the drugs and other medical supplies their treatment required. A nationwide household survey conducted by the National Statistical Committee in 1994 was the first attempt to estimate the level of informal payments and their effect on household well-being. The survey found the following:
  - 69% of outpatients and 86% of inpatients paid something when went to see a provider.
  - For an average inpatient stay, 60% of out-of-pocket payments was for drugs, 18% was for payments to staff, 14% was for supplies for surgery, 3% was for official fees.
  - 25% of people who sought medical assistance in an outpatient setting paid for the consultation itself to the doctor (in addition to payments for drugs, food and travel).
- Just before the introduction of official copayment, a survey of previously hospitalized patients found that the average level of patient expenditures in hospitals varied from 364 soms to 1801 soms[i].

- **Co-payment was introduced to protect low income and gravely ill individuals from impoverishing effects of medical expenditures via transparent and well-defined exemption mechanisms.** The 1994 household survey cited above found that informal payments place a heavy burden on low-income households and those with chronic illness. This was a very surprising finding given physicians in all transition economies claim that informal payments are equitable: those who are able to pay will do so, and those who are not can get treatment for free. Household surveys and patient interviews show a markedly different picture. Findings from 1994:
  - 70% of the poor were not able to fill a prescription compared to 36% in the general population.
  - 32% of the population reported that they could not afford needed health care
  - One in three patients borrowed money to meet medical expenditures
  - In rural areas, 45% sold produce or livestock to meet the costs of hospital care.
  - Other coping strategies to deal with medical expenditures included asking help from relatives, reduce consumption on other items, use up savings.

These findings were confirmed in the 2000/01 household survey of the National Statistical Committee: 1/3 of hospitalized patients paid more than 1,000 soms associated with their treatment through informal payments. Those receiving surgery paid significantly more than this amount[ii]. These very high expenditures are the ones leading to impoverishment. Formal co-payment limits these high expenditures and thus has the potential to reduce medical impoverishment due to medical expenditures.

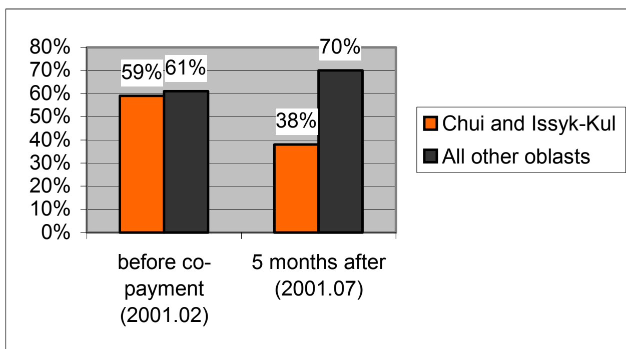
3. Does the co-payment policy work?

WHO has been supporting an annual survey of hospitalized patients to find out if the co-payment policy has indeed reduced the level of informal

payments. Here, we report findings from the surveys conducted in 2001 and 2002 conducted after Issyk-kul and Chui have introduced co-payment but other oblasts had not:

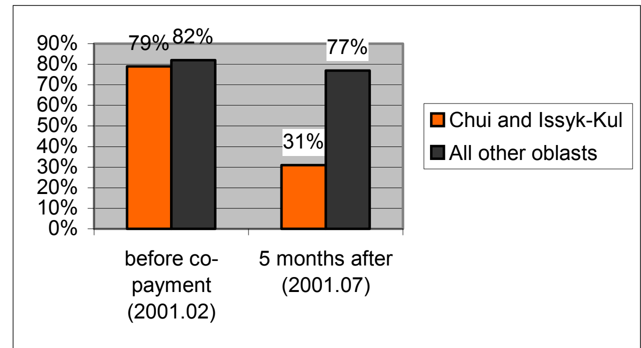
- Payments to health care personnel in Issyk-kul and Chui reduced while such payments increased in other oblasts where co-payments were not introduced (Figure 1a).
  - In Issyk-kul, payments to personnel declined from 64% of patients paying something before the reforms to 28% five months after the reforms, and to 38% of patients a year after the reforms.
  - In Chui, prevalence of payment reduced from 55% of patients before the reforms to 47% at five months after the reforms, and to 45% a year after.
- Similarly, payment for drugs and medical supplies also reduced. (Figure 1b)
- Adding up all payments including the official co-payment and other payments made at the time of hospitalization, it seems that total patient expenditures have neither declined nor increased. This suggests that official co-payment is not an additional resource for the health sector but rather a replacement for the previous system of informal payments.

Figure 1a. Percent of hospitalized patients making payments to health care personnel



- Patients who were exempted from co-payment experienced a 4-fold reduction in their total direct expenditures at the time of hospitalization after the policy was introduced. This was a strong indication that exemptions were working and protecting beneficiaries from the impoverishing effects of expenditures.

Figure 1b. Percent of hospitalized patients making payments for drugs and medical supplies



- Financial uncertainty associated with treatment was reduced where co-payment was introduced. Before introducing co-payment, about 20% of patients responded that they knew in advance what they needed to pay. After the policy was introduced in Issyk-Kul and Chui, 46% of hospitalized patients reported they knew what they had to pay in advance.

4. What do patients think about the co-payment policy?

In addition to quantitative studies, the Kyrgyz-Swiss Health Reform Support Project conducted qualitative studies to elicit patient views about the co-payment policy[iii].

- Acceptance of the policy was mixed but generally positive
- About 75% of interviewed patients say that the co-payment policy is better than the previous system of informal payments. Low-income respondents hold the same opinion that co-payment policy is better than the informal system it replaced.
- Many insured patients pay less with co-payment than they paid previously for the same treatment. This is especially the case for surgical treatment, but also for others;
- Patients know in advance what to pay and can prepare for it.
- Quality of care is better. Particularly, drugs are available and they do not need to purchase

them in the pharmacies. Staff morale and attitude is seen as better and food is available.

- People in general accept that treatment cannot be free of cost. Patients see the sharing of the burden between the state and the individual as fair.

Resources for further information

[i] Survey of discharged patients designed and implemented by WHO, the National Statistical Committee, and the Mandatory National Health Insurance Fund in 2001.

[ii] Jane Falkingham 2001 “Health, health seeking behavior, and out-of-pocket expenditures in Kyrgyzstan in 2001” (DFID funded analysis)

[iii] Tobias Schüth 2001. “People’s perspectives on the co-payment policy: Rapid Appraisal Study in the pilot area of Chui and Issyk-Kul oblasts” Swiss Red Cross.

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