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Fiscal decentralization and options for the Kyrgyz health financing system: reflections on three options

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1 Introduction

The Kyrgyz Republic, as many CIS countries, is embarking on fiscal decentralization. This overall public finance reform process presents some unique problems for the health system. The Kyrgyz health system is very advanced in its health financing reforms. Additionally, 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 order to harmonize the Kyrgyz health financing system with the already legislated decentralized fiscal system, three options have been proposed. This policy paper reviews each of the three options and discusses their strengths and weaknesses. The paper comes out with the conclusion that only one of the three proposed options - so called option 3 - will ensure that previous gains in equity, efficiency and transparency will be maintained. This option would pool all revenues allocated for the State-Guaranteed-Benefit Package (SGBP) in the Mandatory Health Insurance Fund while public health services and services outside of the SGBP would be funded through the Ministry of Health. The other two options would set the Kyrgyz health system back 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.

Health financing policy, like all aspects of health policy, should be driven by goals. WHO has portrayed the goals of health systems in a generic sense, meaning that these broad goals are shared by all countries, though the relative weight given to each varies according to country specificities. These goals are (WHO 2000):

- improving the health status of the population;
- improving equity in the distribution of health among the population (i.e. reducing “unfair” differences in health between individuals and social groups);
- enhancing protection of the population against the financial consequences of using health care, and distributing the burden of funding the health system equitably;
- improving the responsiveness of the health system to the expectations of the population (treating people with dignity, autonomy, respect, etc., and enhancing the client orientation of the system along such dimensions as consumer choice and prompt attention); and
- improving efficiency, i.e. maximizing improvement of all of the above goals within the limits of available resources.

Within the broad scope of system goals, more specific goals for health financing policy can be derived. Some health financing goals are essentially synonymous with these health system goals, while others reflect the contribution of health financing arrangements to wider goals.

Health financing goals that are also broad health system goals

- Protection of individuals and their families against the risk of potentially impoverishing health expenditures
- “Solidarity”
  - Distribution of the burden of funding the system (from all sources) relative to individual capacity to contribute, and

- Equity of access to care relative to the need for care

- Transparency in terms of the entitlements of the population and their obligations (part of responsiveness and also a higher order public policy aim)

Health financing objectives that contribute to wider health system goals

- Explicit incentives that promote quality and efficiency in service delivery

- Efficient administration of financing system

These health financing goals and objectives are performance criteria for health financing systems and hence can be used as criteria to compare different reform options. However, it is important to recognize that health financing reform options do not exist in a vacuum; they point to possible "destinations" for health financing policy. Assessment of the options must therefore also account for the current situation as the "starting point" for any further reform. Further, since the existing Kyrgyz health financing system has been developed in a step-by-step manner since initial pilot work in Issyk-Kul oblast in 1995-96, another important criterion for assessing the options is that the future system should build on the skills and systems that have been developed over the past 10 years.

2 The Kyrgyz health financing system and fiscal decentralization

2.1 The health financing reforms

The Kyrgyz health financing system can be characterized as having had three distinct phases:[1]

Phase 1: The system inherited from the Soviet Union (1991-1996)

Phase 2: The introduction of the Mandatory Health Insurance Fund (1997-2000)

Phase 3: The nation-wide implementation of the Single Payer system (2001-present)

Principally as a consequence of the economic transition from the USSR, the inherited health system was faced with two major challenges. First, there was a decline in overall government spending, which also meant a decline in government health spending. Second, 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. In Kyrgyzstan, such payments were documented as early as 1994,[2] and the available evidence shows that these principally occurred in hospitals. Further, these payments were mostly for drugs and medical supplies that were supposed to be available in the hospital, and, to a lesser extent, also included payments to health workers. The presence and growth of these payments meant that the system had become less transparent.

The inherited health financing system was characterized by major structural problems that became apparent when faced with the challenged of functioning in the context of economic transition. The most important problem was the effect of vertical integration of pooling, purchasing and service delivery, combined with the fragmentation of these integrated systems by level of government (rayon, city, oblast), and the resource allocation process that was driven by input/capacity norms (e.g. budgeting according to the number of beds, number of staff, etc.).

There were two main negative consequences of these fragmented health financing arrangements:

- There was **inadequate risk protection and inequity** relative to what could have been achieved with the same level of public funding. Fragmentation of pooling did not allow re-distribution across administrative levels (e.g. impossible to cross-subsidize from richer to poorer rayons); and

- Duplication of health system coverage and infrastructure caused both **inefficiency** (excess capacity) and **inequity** (concentration of resources in urban areas). The fragmented 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.

[1] For more detail and analysis, see Kutzin et al. (2002). "Innovations in Resource Allocation, Pooling and Purchasing in the Kyrgyz Health System." HPAP Policy Research Paper 21. Available in English and Russian.

[2] See Abel-Smith and Falkingham (1995). "Private payments for health care in Kyrgyzstan." Report to Overseas Development Administration (now DFID). London.

The Single Payer system was designed to address these structural problems and improve performance in the inherited health financing system. The system involves the following features:

- pooling of all local budget (oblast, rayons and cities) funds for health, including categorical grants, in the territorial department of the MHIF (TDMHIF);

- unified system of provider payment using the methods of the MHIF (i.e. case-based payment to hospitals, capitation payment to FGPs) from these budget funds (by the TDMHIF), complemented by additional payments on behalf of insured persons from the national MHIF pool;

- purchaser-provider split, ending vertically integrated financial relations between public sector purchasers and providers, coupled with the extension of greater autonomy to providers including a reduction in line item constraints on the use of budget funds; and

- promulgation of the State Guaranteed Benefit Package, including formal co-payments for specialist referral care.

In this system the MHIF is the "Single Payer" for the State Benefit Package, and it also the single agency that pools prepaid funds. While funds for the insured population are pooled at national level, local budget funds are pooled in each TDMHIF for the entire population of each territory.

The pooling of funds at oblast level ended the fragmentation that had existed previously within oblasts, and the purchaser-provider split and shift to output-based payment methods ended the previous vertical integration and hierarchical, input-based budget allocation process. The State Benefit Package with formal co-payment was intended to improve transparency with regard to both the entitlements and obligations of the population. This latter included improving the functioning of mechanisms to exempt from payment persons in defined "vulnerable" or "privileged" categories of the population. Such exemptions were always in place, but the evidence shows that, prior to the reforms of 2001, they were not effective.[3]

2.2 Impact of health financing reforms on health system goals

The effects of the Single Payer reform have been thoroughly analyzed; indeed, this is undoubtedly the best-documented reform of all the countries of Central and Eastern Europe and Central Asia. Several reports[4] are available from the WHO/DFID Health Policy Analysis Project, and in-depth analysis is ongoing. Much of the analysis, particularly related to the implementation of the co-payment, is based on surveys. HPAP funded and analyzed surveys of discharged hospital patients throughout the country, using a standard questionnaire (also available, in English and Russian, from the HPAP office). The baseline survey was conducted of patients discharged in the month prior to the introduction of the co-payment, and the first follow-up survey was made of discharged patients from July 2001 (the fifth month of policy implementation). Further surveys were made of patients discharged in March 2002 (Chui and Issyk-Kul only), and additional surveys were implemented in 2003 and 2004. Well over 10,000 discharged hospital

[3] See Kutzin (2003). "Health expenditures, reforms, and policy priorities for the Kyrgyz Republic." HPAP Policy Research Paper 24. Available in English and Russian. Also see Falkingham (2001). "Health, health seeking behaviour and out of pocket expenditures in Kyrgyzstan 2001." DFID-funded Kyrgyz Household Health Finance Survey: Final Report. London: London School of Economics and Political Science. English only.

[4] See the two papers (Kutzin 2003; Kutzin et al. 2002) previously cited. Also see several of the HPAP Policy Briefs.

patients have thus been interviewed. All the surveys were implemented by the National Statistical Committee.

Here, we just summarize the results of these analyses, organized by the health financing goals outlined in the Introduction.

2.2.1 Transparency

Perhaps the greatest success of the Single Payer system has been the improvement in the transparency of the system to the population. This is reflected by the evidence showing that, in the first year of implementation, informal payments were reduced substantially and replaced by the co-payment. In fact, the data indicate that, on average, patients paid about as much after the co-payment as before, reflecting remarkable accuracy in the calculations made by the MHIF in planning the co-payment levels. Further, the methods used by the MHIF to "purchase" free care for the exempt population (i.e. paying hospitals more to treat people in these groups) were successful, while in the regions that did not yet have the reform in place, the right to exemption remained an empty promise. After the reform in the Single Payer oblasts, the percent of patients who paid for drugs or made payments to staff was greatly reduced. The data also show that the uncertainty that patients had about what they would have to pay for care was reduced after the Single Payer was introduced. In short, the Single Payer led to greater understanding by the population of their entitlements and obligations; the reform had a positive impact on the transparency of the health system.

Beyond the success of the MHIF in improving transparency of the health system, the MHIF itself has been assessed to be a "clean" and transparent organization. An independent audit implemented in October 2004 concluded that all MHIF procedures were consistent with Kyrgyz legislation and international standards.

2.2.2 Financial protection and equity

The patient survey data only allow limited conclusions to be reached about the impact of the reforms on financial protection and equity. Positive effects on both are suggested by the findings that vulnerable categories of the population paid much less for hospital care in the Single Payer regions than elsewhere in the country. In addition, the structure of the co-payment – a fixed amount per hospitalization – combined with the success in reducing informal payments for drugs suggests an improvement in protection against financial risk. Prior to the co-payment, the level of out-of-pocket spending was driven principally by the actual costliness of the case. Hence, the more complex and costly the treatment required, the higher the out-of-pocket payments. The co-payment seems to have broken this link. For example in Issyk-Kul in 2001, the spending gap between surgical and medical patients was reduced from 38% to 11% in the oblast hospital and from 72% to 20% in rayon hospitals.

2.2.3 Incentives for efficiency and quality in service delivery

By ending input-based budgeting and paying hospitals per case, incentives for providers were reversed from trying to expand capacity through increased length of stay to trying to increase productivity, reduce length of stay, and most importantly, reduce fixed costs. Analyses[5] again

[5] Socium Consult (2002). "Funding of the health sector: improvements of health indicators and health sector reform." Background paper for the World Bank Public Expenditure Review for the Kyrgyz Republic. Bishkek.
HPAP Policy Brief #6 (2004): "Did restructuring of health facilities reduce utility costs?" Bishkek.

points to success in this regard. The number of hospital beds and buildings were reduced substantially in Chui and Issyk-Kul in 2001, as were the numbers of doctors and nurses. The share of fixed costs (utilities and salaries) in total health facility spending was reduced from 86% to 73% from 2000 to 2001, revealing how the combined effects of the incentives for restructuring and the formal co-payment revenues (now reflected in accounting systems and subject to the control of hospital managers) led to an improvement in the technical efficiency of service provision (i.e. a greater share of resources devoted to patient care inputs). 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.

Quality improvement was one of the main objectives of the Additional Drug Package (ADP) introduced by the MHIF on a pilot basis in Bishkek in 2000 and then later extended nationally. The ADP provides one of the best examples of "strategic purchasing" by the health systems of the European region. More specifically, the package was linked to clinical guidelines for specific conditions for which outpatient management with appropriate medicines could prevent hospitalizations. Again, the evidence showed that the method used by the MHIF was effective: coordinating the list of covered drugs, financial incentives, and standard treatment guidelines promoted rational use of medicines. As use of the ADP increased, for example, hypertensive crises were reduced, as were referrals to hospital for conditions related to hypertension.

2.2.4 Administrative efficiency

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. Yet they are constrained by law to ensure that their administrative expenses 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).[6] Its ability to manage these tasks, as well as a high volume of transactions, speaks to both its administrative efficiency and technical sophistication.

2.3 Persistent challenge: ensuring adequate funding

The main problem facing the MHIF in its implementation of the Single Payer system has been the inconsistency in the flow of funds into the system from both local and Republican budgets and, until recently, the Social Fund. While the Single Payer resulted in great improvement in the transparency of financing arrangements within the health system, the flow of funds to the health system has been problematic. Budget formation by local governments and the determination of categorical grants for health have remained input-based, and local authorities also have taken into account co-payment revenues when deciding how much of their budget to allocate to health. This was implicitly pretending that the co-payment was a new source of funds rather than a transformation of the existing informal payments to the formal co-payment. So as a result of improving transparency, budgets for the health system were cut. Cuts also occurred because of the efficiency gains that led to reduced numbers of hospital beds and health staff. A priority for the future is to change the budget formation process so that overall budget allocation processes reflect stated priorities for health in the context of the National Poverty Reduction Strategy and the Medium Term Budget Framework.

The Single Payer system also suffers greatly from the "sequestration" of the budget by the MOF. Because the system is based on contracts between the MHIF and providers, the expected level of funding must be known in order to set reimbursement rates and volumes appropriately. And

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

the flow of funds must be routine to facilitate regular payment to providers without arrears. Sequestration therefore greatly damages the system.

The combination of budget cuts that have effectively punished the success of the reforms, combined with the problem of sequestration, have almost certainly undercut the success that the reforms achieved in 2001. Reportedly, informal payments have increased as a result.

Despite these problems, it is clear that the Single Payer system works, and that the MHIF has been an effective, transparent, and sophisticated implementer of the system. Of course, the system works best when it is funded in a predictable and stable manner, and hence improving the wider public budgeting and finance system is essential for the further development of the system. Such improvements are planned by the MOF in the context of overall efforts to improve governance and also of the efforts to make implementation of the Medium Term Budget Framework meaningful and relevant to the annual budget process.

2.4 Fiscal decentralization

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:

- budgets of local self-governments (Ayil Okmotus + cities which have elected self-governments); and

- Republican-Oblast-Rayon budget all pooled at the national level.

The future Republican budget will have a different meaning from its current use to mean an aggregated pool of money collected from Republican taxes, oblast and rayon taxes. There will be no one-to-one mapping of current revenues of these three levels into the future "Republican budget" because of complex revenue sharing arrangements.

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.

Then, the question for the Single Payer system is whether to move down to full decentralization of health financing to the local government level with fragmented pooling, or up to full centralization with national pooling. Alternative 1 in the strategy corresponds to full decentralization with fragmented pooling arrangements. Alternatives 2 and 3 are different institutional variants of centralizing pooling at the national level. Alternative 2 proposes centralization under the MOH while alternative 3 proposes centralization under the MHIF. In the next chapter, we review these options in details.

3 Assessment of Options for Further Reform of Health Financing

As noted in the introduction, understanding the current situation is the starting point for further reform, while the health financing policy goals should drive the direction of reforms. Hence, the starting point is the arrangements under the Single Payer for revenue collection, pooling, purchasing, and benefits/co-payments. In addition, the new Law on Local Self-Government has important implications for pooling of funds. It is in this context that the 3 options for health financing reform are considered.

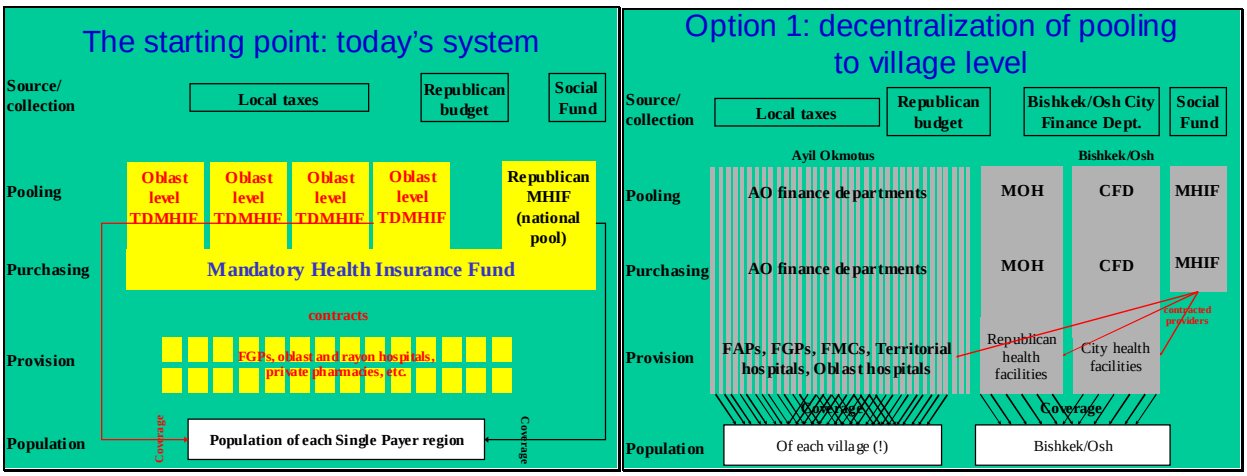
The critical distinction between the options is the arrangements for pooling, and by extension, for purchasing of personal health care services. In the description and assessment of each option, other details that do not vary between the options (e.g. the high-technology fund) are not addressed.

- **Option 1**: 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

3.1 Assessment of Option 1



In today's single payer (summarized in the figure to the left, above), there is a pool of local budget funds in each oblast managed by TDMHIF (in the figure, this is shown for 4 oblasts, but meant to reflect all oblasts and Bishkek/Osh cities). Under Option 1, this would change radically. The MHIF would only pool and purchase on behalf of the insured population, while local governments (under the new law, these would be principally *ayil okmotus*, as well as the municipalities of Bishkek and Osh) would pool and purchase from budget funds.

The fragmentation of the financing system that would result from this option (over 400 micro-pools responsible for allocating funds to providers) would prove damaging to a number of policy objectives.

- **Financial protection and equity of access would suffer** because this extreme fragmentation of pooling greatly limits the scope for cross-subsidy and redistribution in response to need. While the current Single Payer system at oblast level facilitates such redistribution within oblasts (an improvement from the past when pools also existed at the rayon level), option 1 would constrain the scope for such redistribution to the ayil okmotu level. Further, it would be very difficult to work out a budget equalization mechanism that could balance the level of per capita funding for over 400 ayil okmotus.

- **Administrative efficiency of the health financing system would be greatly diminished**. Hundreds of ayil okmotus would have to take on pooling and purchasing functions that are currently implemented by a single agency, the MHIF.

- This option would **undermine the potential to use strategic purchasing methods to generate incentives for efficiency and quality in service delivery**. The coherence of the current system of unified purchasing would be lost. Further, it is just not possible that the ayil okmotus would be able to implement the sophisticated payment methods that are used currently by the MHIF. Further, because there would not be a hospital in each village, each hospital would have to be paid by several ayil okmotus, again complicating the ability to offer a coherent set of incentives to hospitals.

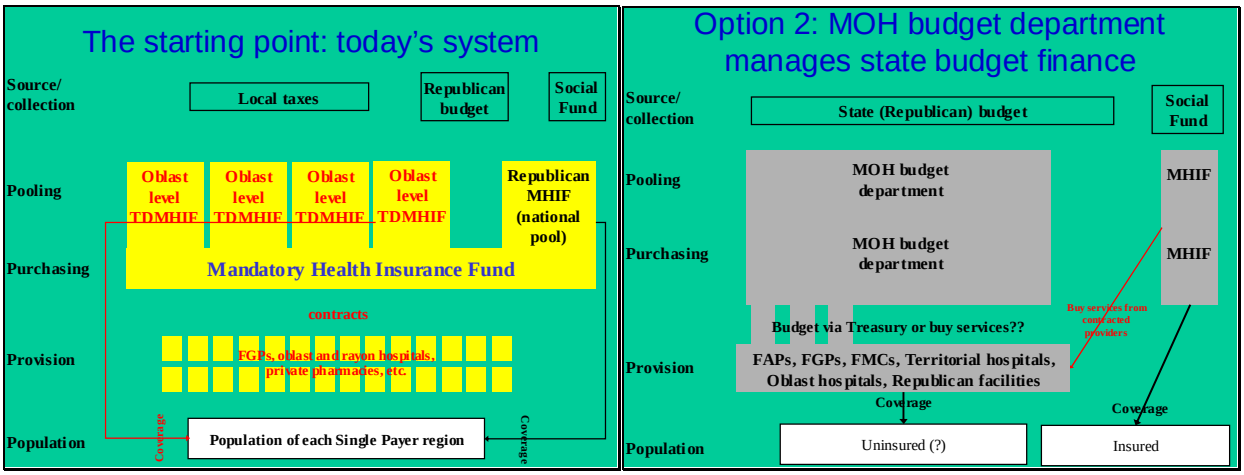
- The **impact of this reform on the transparency of the system is not entirely clear, but would probably be more negative than positive**. Given the great difficulty in balancing revenues per capita across pools, there would be a risk of great variation in the entitlement (i.e. benefits and co-payments) actually available to the populations of different villages, even if legally they were entitled to the same thing. On the other hand, more local control may enable the population to demand clarity from local elected officials with regard to their entitlements.

- This option would not imply any direct change in the source of funds, and so **equity in financial contribution would not be immediately affected by this option** (or the others). However, the administrative inefficiency that would arise from this option would eventually cause an increased share of public funding to be devoted to administration rather than patient care, and as a result, there would have to be greater reliance on out-of-pocket spending by patients. In turn, this would mean greater inequity in financing.

Overall, this option is just not feasible. The extent of fragmentation and duplication implied by this option would make it virtually impossible to implement.

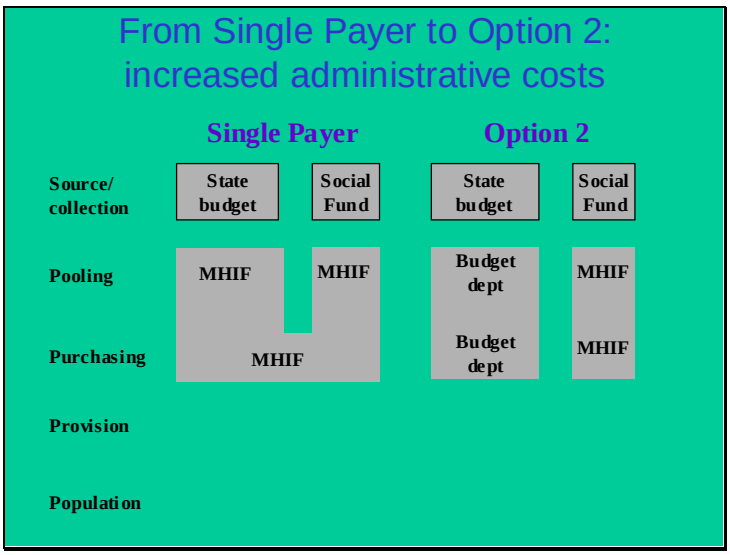
This assessment does not reflect an “anti-decentralization” position. However, it does reflect a perspective that treats decentralization a policy instrument, not a policy objective. In this regard, decentralization should not be used as a “blunt instrument”. When making choices about how to organize functional responsibilities and resource allocation decisions in a health system, decisions on the level to which functions are to be decentralized should be guided by the likely impact on policy objectives. Because of the negative impact of fragmentation of pooling on equity, efficiency, and risk protection, pooling of funds should be centralized. Conversely, it is often recommended that to improve efficiency and responsiveness, responsibility for management of service delivery should be decentralized directly to health facilities.

3.2 Assessment of Option 2



The main aspects of this option that it would create a Republican level pool of budget funds for health managed by the MOH (identified here as the MOH budget department), while maintaining the Republican level pooling of funds for the insured population (transfers from the Social Fund and Republican budget for the categories of the population defined as insured). By establishing the MOH budget department as a purchaser of personal health care services, the Single Payer system would no longer exist. Some other specific features of this option were not specified in detail, but some implications of this option for the purchasing of services and for population coverage are likely and are addressed below in a step-by-step manner, following the assessment of the basic features of this option.

By creating parallel systems for pooling funds and purchasing personal health care services, this option would increase administrative costs. The MOH budget department would pool all state budget funds for health care and allocate these to providers. The MHIF role would be reduced to accumulating only "health insurance" money and purchasing services from these. As compared to the current situation, this would create a duplication of functional responsibilities between two agencies that are under the MOH (both the budget department and the MHIF would need staff, systems, etc.), as shown in the figure below.

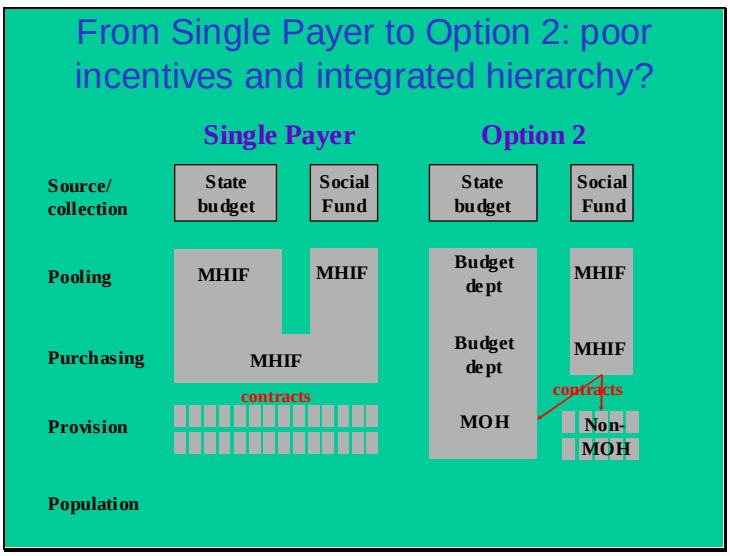


In addition to the increase in administrative costs that would occur, Option 2 also risks wasting investments that have been made since 1997 in the people and systems of the MHIF. The MHIF has become a very sophisticated purchasing agency, managing payments for a high volume of transactions on behalf of the entire population of the country. By returning to the situation that existed between 1997 and 2000, when the MHIF only purchased services on behalf of the insured population, the health system would not be taking full advantage of this.

While it is conceptually possible that budget funds can be pooled by the MOH and providers paid from this, the history of health financing reform in Kyrgyzstan casts great doubts on the ability of the MOH to implement this within the "core public sector". Previous attempts to pool budget funds within the "normal" Treasury system mechanisms proved unsuccessful. In 1998 in Issyk-Kul oblast, budget funds were pooled at oblast level for primary health care. However, this pooling was withdrawn the following year. It was also planned to pool budget funds for inpatient care in Chui oblast in 1999 in the oblast health department, but it was not possible to implement this. The MHIF is only agency in the Kyrgyz health sector that has demonstrated success at pooling at oblast and national levels, and already has demonstrated capacity and systems to purchase services nationally.

As noted previously, certain aspects of Option 2 are not spelled out in detail, but would be likely to occur under this approach. Two important aspects are highlighted below.

1) The MOH budget department would not be able to purchase services "strategically" and would return to the use of hierarchical line-item input control to allocate resources through a system that would be vertically integrated with providers. The shift from the current arrangements under the Single Payer to that likely to occur under Option 2 is shown in the figure below.



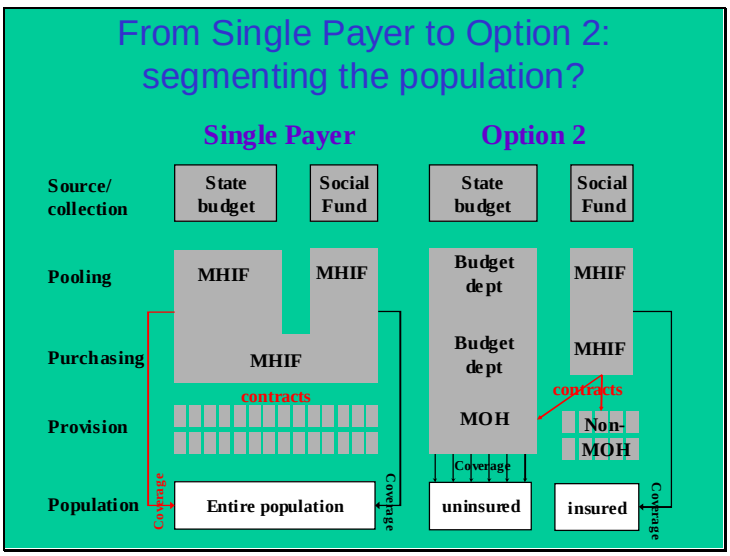
Under the current Treasury arrangements of the Kyrgyz public finance system, the MOH budget department would legally have to "budget" all government health facilities, rather than enable these facilities to "earn income" the way they do now from the MHIF. In addition to this administrative constraint, the MOH simply does not have the systems in place to implement output-based payment.

As reflected in the figure, this option would also risk creating a conflict in payment incentives between those used by the budget department and those used by the MHIF. This loss of complementarity would reduce the risk protection potential of public spending on health. By creating two purchasers, overall "purchasing power" would be weakened, which in turn would reduce scope to use incentives to promote improved efficiency and quality of service delivery. Much worse, as noted previously, the MOH budget department would be likely to return to input-

based budgeting, 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. Control over all resource allocation decisions would be much more centralized in the MOH, contrary to the principles of good stewardship.

Experience from another CIS country suggests important advantages from keeping provider payment systems outside of the usual Treasury controls within the core public sector and giving providers more managerial autonomy. In Moldova, overcoming the administrative and systemic constraints of managing the health financing system within the Treasury system was the motivation for the Minister of Health to create a reform that introduced a compulsory health insurance fund in 2004.[7] The main source of funding for the Moldovan "National Health Insurance Company" (NHIC) is transfers from the Republican budget that had formerly gone to the MOH. The Moldovan reform also involved creating a purchaser-provider split and giving increased autonomy to providers over how to use the revenues they earn from the NHIC. The financial situation is much more favorable now for providers. Under the old treasury budget allocation process, execution of payments took 2-3 weeks. In 2004, this was reduced to 1-2 days under a system in which the NHIC pays directly to the commercial bank accounts of providers.

2) The health system, and the population, would be divided into separate systems for the insured and uninsured. This segmented health system arrangement occurs in many low and middle-income countries, particularly in Latin America, with Mexico being an important example. In fact, when the Kyrgyz government announced that the MHIF was to be introduced in 1997, implementation of the 1st World Bank-funded health project was postponed until a solution was found that would avoid both duplication and segmentation of the population. Among many arguments made at the time, one of the most important was that Kyrgyzstan could not afford to have two health systems. But this is the logical extension of Option 2, and is shown below.



In addition to the higher administrative costs of having duplication of pooling and purchasing responsibilities, the segmentation of the population by insurance status reduces potential for financial protection by dividing the population into different risk pools. This contrasts with the current Single Payer system under which the entire population is covered from budget funds, while those who are insured are entitled to additional benefits (reduced co-payment and the Additional Drug Package). Population segmentation would mean that budget and insurance revenues would no longer be used in this complementary manner.

[7] Indeed, their decision to implement this reform was based in part on a review of the Kyrgyz Single Payer experience.

International experience suggests this segmentation increases inequality in service availability and access, and many of these countries are trying to unify their systems. In both Thailand and Turkey, for example, the population is segmented into different insurance schemes, and the level of per capita government spending differs across the schemes but has been much greater for the schemes serving the relatively privileged part of the population. Both countries are trying to move away from this segmentation and implement universal coverage in a single pool funded from both payroll tax and general revenues.

Overall, and relative to the existing Single Payer system, Option 2 would have a negative impact on health financing policy objectives:

- The potential to promote **financial protection and equity of access would be reduced** because fragmentation of pooling and the likely segmentation of the population would promote inequality and limit the scope for cross-subsidies to flow to those in need.

- **Administrative efficiency would be damaged** by the increase in administrative costs that would arise from the duplication of functional responsibilities for pooling and purchasing in the MOH budget department and the MHIF. At best, there would be a long and costly transition period to the new system that would replace the Single Payer.

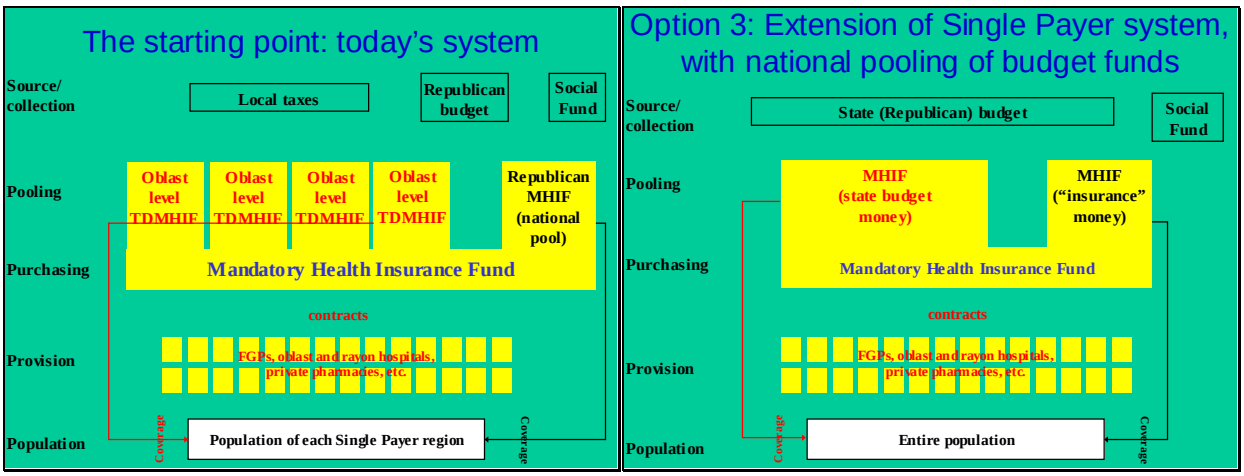
- There would also be **reduced potential to use purchasing incentives to improve efficiency and quality** of service delivery. This would arise due to weakened purchasing power inherent in the shift from one purchasing system (and agency) to two, and more importantly from the likelihood that the MOH would rely on input-based budgeting to allocate resources to providers.

- By re-integrating the management of budget funds for personal health care services into the "core" MOH, **transparency is likely to suffer**. Unlike the current system in which there is a separation of functional responsibilities between agencies and providers are paid based on explicit contracts and reimbursement methods, re-integration of this function into the MOH would make resource allocation decisions implicit. In that context, the scope for non-transparent practices would be greater, and monitoring of the system would be harder to implement. In addition, if the population is segmented, entitlement to benefits is likely to differentiate as well, and the improved population understanding of their entitlements and obligations that has occurred under the Single Payer is likely to be reduced.

- This option would not imply any direct change in the source of funds, and so **equity in financial contribution** would not be immediately affected by this option. As with Option 1, however, the administrative inefficiency that would arise from this option would eventually cause an increased share of public funding to be devoted to administration rather than patient care, and as a result, there would have to be greater reliance on out-of-pocket spending by patients. In turn, this would mean greater inequity in financing.

Technically, this option is feasible in the sense that it could be implemented. However, it would be costly and very risky in terms of outcomes for the population.

3.3 Assessment of Option 3



This option would be an extension of the current Single Payer system. The change implied (in the context of the new budget law) is to move from oblast-level pooling of budget funds to Republican level pooling of funds by the MHIF. All other features of the current system (i.e. sources of funds, purchasing arrangements, and the State Benefit Package) would remain intact.

Option 3 represents continuity with current arrangements. It would maintain, extend, and solidify the role of the MHIF in the financing system, building on earlier investments and experience. In so doing, it would facilitate progress towards the policy objectives along a number of dimensions. And unlike the other options, Option 3 does not do any direct harm to these objectives.

Because the extensive evidence on the impact that the Single Payer system has already had on policy objectives was described earlier, the likely effects of moving to Option 3 are summarized below.

- The potential to promote **financial protection and equity of access would be increased** because the shift from oblast level pooling ("Single Payer in each oblast") to Republican level pooling of budget funds offers greater scope for cross-subsidization in response to need, and for the implementation of pro-equity resource allocation measures.

- **This option would not have direct implications for administrative efficiency of the financing system**, although the need to only negotiate the level of budget at the Republican level, rather than at oblast and rayon levels, would reduce administrative burden**.** Although pooling of budget funds would move to the national level, the Territorial Departments of the MHIF would still be needed to implement functions other than pooling that they currently undertake (e.g. data collection, utilization review, administration of payments, "hotline" for consumer complaints, etc.). Overall, therefore, administrative efficiency is not likely to be affected or may improve slightly as a consequence of the shift to Republican level pooling of budget funds.

- Since this option would maintain the Single Payer system, there is also **unlikely to be any direct effect on the potential to use purchasing incentives to improve efficiency and quality** of service delivery. Currently, the MHIF is the single purchaser, and with Option 3, this would still be the case. Of course, this continuity means that the ongoing process by which the MHIF manages and improves its purchasing methods would continue, and so it is likely that in the medium term, this option would also contribute towards an improved incentive environment (particularly compared to what would occur under the other two options).

- **Transparency is likely to improve** as a result of the ongoing development of the State Benefit Package combined with the source of budget funds coming entirely from the Republican level. As noted previously, improvement in the transparency of the health financing has been one of the principal accomplishments of the Single Payer, but this gain has been threatened by the instability in funding flows coming from local governments. By shifting to a single source of funds, it will be possible to exert more leverage on the budget formation and execution processes for the entire system, thereby enabling the transparency-enhancing methods of the MHIF to work more effectively.

- As with the other options, Option 3 would not imply any direct change in the source of funds, and so **equity in financial contribution would not be immediately affected** by this option. Unlike the other options, however, Option 3 will not make the administration of the system more inefficient, and hence would not contribute over the longer term to an increased dependence of the system on out-of-pocket payments (unless, of course, the level of government spending on health declines)

Technically, this option is entirely feasible to implement. The MHIF is currently implementing the purchasing function at the national level, and is already managing all the budget funds for personal health care services. So as the source shifts from local budgets to the Republican budget, there would be no disruption at all to the systems and processes of the MHIF as it would continue to manage the Single Payer system.

4 Conclusion

Option 3, the extension of the current Single Payer system, is clearly superior to the other options. It is the best choice in terms of the objectives of health financing policy, particularly administrative efficiency, the potential to offer incentives for delivery system efficiency, financial protection, and equity of access to care. It is also the best choice for practical reasons, building on the donor investments and the systems and skills that have been developed in the MHIF since 1997. The Kyrgyz Single Payer system managed by the MHIF represents an example of "international best practice" in pooling and purchasing methods.

It took five years to build the foundations for the current system, and another four-five years of implementation experience has since been gained. The systems to operate the Single Payer are now in place. It would take at least another five-ten years to develop and implement the other options. Developing either of the other options would be very costly, and would certainly take resources that could have gone to improving the health and financial protection of the population and instead sink them into administrative costs. Furthermore, these other options would still be very unlikely to work as well as the current Single Payer system. So there is simply no good reason for the government to change direction and shift to Option 1 or Option 2.

The Single Payer system, managed by the MHIF, has demonstrated its capacity to use funds effectively and to the benefit of the population. The Kyrgyz Single Payer reform has been extensively analyzed, and the evidence shows clearly that the MHIF, through its purchasing methods, has been an effective instrument of national health policy. The Single Payer also provides a very positive model to other countries of how to organize a health financing system in a country that is experiencing economic transition.