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PERCEPTIONS OF THE CO-PAYMENT POLICY AMONG PATIENTS AND HEALTH PERSONNEL: RAPID APPRAISAL STUDY IN THE PILOT AREA OF CHUI AND ISSYK-KUL OBLASTS

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Abbreviations

CRH	Central Rayon Hospital
FGP	Family Group Practice
MHIF	Mandatory Health Insurance Fund
OMH	Oblast Merged Hospital
PRA	Participatory Rural Appraisal
SRC	Swiss Red Cross
WHO	World Health Organisation

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Executive Summary

1. A new way of financing hospital care is being piloted in two oblasts of Kyrgyzstan since March 1, 2001. It is called "co-payment policy" for its main new feature of demanding a user fee at entry into hospital. The level of this fee varies between 0 and 1890 Som, depending on insurance status and other factors. The Health Policy Analysis project of the WHO has asked the Swiss Red Cross to conduct this qualitative study on the perception of the co-payment policy by people and health care providers. The main issues the study was supposed to investigate were
   a) how people and staff perceive the co-payment policy,
   b) whether in general the co-payment policy functions as it is supposed to function, and
   c) whether there is an access barrier to hospital care for poor people because of the co-payment at entry.

2. The study was done in October 2001. It was designed in three tiers. People's perception was investigated in 31 group sessions in villages with 246 patients released from hospitals; of these 207 had been treated under the co-payment policy (including 16 who had been also treated under the previous system), 39 only under the previous system. In these sessions participants used tools designed according to principles of PRA (Participatory Rural Appraisal) to discuss and document their opinions. Hospital staff's perception was investigated in a one-day workshop with 19 staff from 6 Central Rayon Hospitals. Lastly, 9 focus group discussions were held with FGP staff specifically to investigate the issue of accessibility for poor patients.

3. Most people are aware that hospital treatment now requires a co-payment at entry into the hospital. Most of them do not know exactly how much they would have to pay although most do know their insurance status. But people know that they have to pay less if they are insured.

4. At present the co-payment policy fulfils partially its major function of replacing all other hospital related expenditures of patients. Almost all patients (96%) paid the correct amount of co-payment according to their insurance status. A majority of patients (59%) made no additional expenditures for their hospital treatment while 41% of patients did pay something beyond the required co-payment. These additional payments were almost exclusively (88%) directly related to the treatment of the patient, i.e. to buy additional drugs (24% of patients), diagnostic tests (7% of patients) or to contribute small things in kind[1] (21% of patients). In average these expenses amounted to 132 Som in addition to the co-payment. The average amount of additional payments was much higher in Chui oblast (319 Som) than in Issyk-Kul oblast (57 Som). On the other side, informal payments to staff (bribes) are rare. Only 10 patients (5%) were required by staff to make 15 informal payments. Most of these seem to be standard rates demanded by staff in certain departments of certain hospitals. The average paid by these 10 patients was 403 Som (454 Som in Chui, 200 Som in Issyk-Kul). The average of the total extra costs (expenses for treatment and informal payments to staff) amounted to 196 Som (453 Som in Chui and 74 Som in Issyk-Kul).

   These findings seem to suggest that hospital staff has the impression that the resources they receive are not fully sufficient to treat their patients and that they therefore ask them

[1] Things in kind do not include food brought from home. The study did not investigate expenditures for food.

to contribute to their treatment. This is supported by findings from the workshop with hospital staff who - while praising the better supply with drugs under the co-payment policy - complained that there are problems with supply. Given that the MHIF receives only a part of its due from the Social Fund this may well be a reason. However, the considerable difference between additional payments in Chui and Issyk-Kul suggests that there may be other factors at play as well, for example differences in treatment schemes or economic status of the population.

5. Despite of these shortcomings, people as well as staff perceive the co-payment policy clearly as an improvement over the previous system. The most important factor for this is certainly that patients' expenditures for hospital treatment are lower now than before. In average the costs for hospital care, including all expenditures beyond the co-payment, was about 2.5 times lower for patients under the co-payment policy (491 Som) than for those under the previous system (1342 Som).

6. In addition patients perceive a considerable increase in quality of care under the co-payment policy. A majority of patients said they did receive all drugs free of cost during their stay (60% of patients[2]) as well as free diagnostic tests (75% of patients) as compared with only 20% and 56%, respectively, of patients under the previous system. Food quality was rated to be good by 40% of patients under the co-payment policy, vs. 16% under the previous system. Staff attitude, although assessed to be good by 69% of patients under the previous system, was even better perceived under the co-payment policy, where 85% of patients said it was good. Finally, an assessment of the overall satisfaction with the hospital stay showed that 61% of patients under the co-payment found it to be good vs. 38% of patients under the previous system.

   Asked to compare directly both systems and to say whether the co-payment policy was overall worse, equal to, or better than the previous system 70% of participants said that the co-payment policy was better, 23% worse, and 7% equal (figures for all services except deliveries). The major reason given for this positive judgement was that 570 Som per treatment is much more affordable than hospital treatments before. Patients perceive as another major advantage that now they do not have to go around and buy drugs from pharmacies, as these are now mostly available in the hospital. Especially in emergency cases this allows for prompt and effective treatment. Many of those who judged the co-payment policy to be worse than the previous system were uninsured. They argued that 1140 Som is a high amount difficult to arrange. Some said that the co-payment prevented them from going to a hospital.

7. The co-payment does not seem to be a major barrier for poor people to access hospital care. Participants in the village group sessions as well as FGP staff knew only of a few instances where the co-payment had prevented patients to seek hospital care. A major reason for that seems to be the fact that a certificate of the Ail Ökömötü about the poor

[2] The percentages reported in this paragraph cannot be correlated to the figures given in paragraph 4 above, as the tool used to generate the percentages in paragraph 6 allowed for subjective voting on the *perception* of complete coverage with e.g. drugs. For example, as reported in paragraph 4, 24% of percent of patients had extra expenditures for drugs and treatment material; i.e. 76% did not have such expenditures. However, the fact that with the second tool (see methodology for details) only 60% of patients said that they had received all drugs free of costs can be interpreted as meaning that there were a number of patients who felt they had not got all drugs they actually needed, but also were not asked to purchase additional drugs. The same applies to other differences between figures of paragraphs 6 and 4.

economic condition of a patient will give him or her access to free hospital care. Analysing the comparison between the two systems separately for poor patients corroborates this assessment. 68% of poor patients said the co-payment policy is overall better than the previous system, 22% worse and 9% equal. However, brucellosis seems to pose a special problem. Many newly identified cases do not seek proper treatment because they cannot pay three times the admission fee for the three necessary hospital stays within a short time.

More frequent seem to be patients who delay hospital treatment because they either try to avoid hospitalisation and co-payment until no longer possible or are saving or collecting the money needed for co-payment. This phenomenon was mentioned by hospital staff, FGP staff and patient groups.

8. The exception to this overall positive picture is the perception about co-payment for deliveries. With the present rate of 570 Som for a normal delivery most mothers (68%) said the co-payment policy was worse than the previous system, while 27% said it was better. Asked about an acceptable level of co-payment for normal deliveries about half said it should be free of cost, the other half voted for a co-payment between 100 and 300 Som. On the other hand, about half consider a co-payment of 600 Som acceptable for a pathological delivery, while a fourth of mothers suggest it to be free of cost.

9. Staff of Central Rayon Hospitals saw the co-payment policy clearly as better than the previous system, both, in regard to quality of care for patients and in regard to the situation of health personnel. Of 19 workshop participants 16 thought it is better than the previous system in regard to quality of care for patients, 2 said it is worse, 1 saw no difference. In regard to the situation of hospital staff 15 votes said it was better, 3 worse than the previous system (one vote missing).

   In regard to quality of care the reasons given for this positive comparison with the previous system were (in order of frequency): improved supply of hospitals with drugs, better emergency care, diagnostic services free of charge, and better care for exempted categories. Those who saw a decrease in quality of care wrote that the co-payments lead to delayed or avoided hospital admissions.

   Regarding the situation of staff the main reasons given for the positive comparison to the previous system were (in order of frequency): Better morale of staff because they are able to serve the patients better; it also results in an increase in respect from the patients. And increased salary (although mostly very small increase). Those three staff who perceived the situation of health personnel worse than before argued that the methodology of the co-payment policy is not thoroughly worked out and that salary increase is insignificant.

1. Introduction

A new way of financing hospital care is being piloted in two oblasts of Kyrgyzstan since March 1, 2001. It is called "co-payment policy" for its main new feature of demanding a user fee at entry into hospital. The level of this fee varies between 0 and 1890 Som, depending on insurance status and other factors.

Shortly after introduction of this policy in the pilot oblasts the Swiss Red Cross, on behalf of the Ministry of Health and the Health Policy Analysis project of the WHO, conducted a Rapid Appraisal study on people's view about the new policy.[3] This very limited study brought the following main results:

1. Overall the co-payment policy functions as it should. It achieves its main goal of replacing with one user fee all other formal and informal payments.
2. People voiced a clear rejection of a co-payment of 1140 Som for normal deliveries
3. Apart from deliveries there is an overall cautious support for the new policy among the population

Two extensive surveys comparing users' experience before and after the introduction of the co-payment policy are being implemented in 2001.[4] In order to complement the findings of these quantitative studies the Health Policy Analysis project of the WHO asked the Swiss Red Cross to conduct a second, more extensive, qualitative study on people's and health care providers' perception of the co-payment policy.

2. Objectives of the study

The main objective of this study was to assess people's and health care providers' view on the new co-payment policy in the two pilot oblasts, Chui and Issyk-Kul.

Of specific interest were the following questions

- Does the co-payment policy function in the way it is supposed to function and where are problems?
- What is the general level of satisfaction with the co-payment policy among population and staff?
- How does it compare in the eyes of population and staff with the previous system of financing hospital care?
- Does co-payment policy create a problem of accessibility, especially for the poor?
- How is the current rate of 570 Som for a normal delivery accepted by the population?
- What is the level of awareness on the co-payment policy in the general population?

[3] Schüth, T. (2001). "People's Perspectives on the Co-payment Policy: Rapid Appraisal Study in the pilot area of Chui and Issyk-Kul Oblasts". Manas Health Policy Analysis Project, Policy Research Paper 8. Bishkek, Kyrgyzstan: World Health Organization and MOH.

[4] These surveys are funded by the WHO Health Policy Analysis Project. The first of these was implemented in May-June, for patients discharged in February. The second is being implemented in December, for patients discharged in July.

3. Methodology

3.1 Type of study

Rapid appraisal in three tiers using tools of Participatory Rural Appraisal (PRA)

Tier 1: Rapid appraisal with 246 people who had been treated in hospitals
Tier 2: Workshop with 19 head of departments and nurses from 6 Central Rayon Hospitals
Tier 3: Focus Group discussions with staff from 9 FGPs

3.2 Rapid Appraisal among people who have been treated in hospitals

3.2.1 Location

14 hospitals were selected, 7 in each Oblast (see table 1). Both, OHM and 6 CRH in each Oblast were selected in such a way that remote and more central areas were covered. Of the total of 31 sessions held, 28 were done with participants living in rural areas, 3 with participants living in urban or suburban areas.

Table 1: Breakdown of locations

	Hospitals where participants received treatment	No. of sessions
Chui Oblast	Oblast Merged Hospital	2
	Sokuluk	2
	Tokmok	2
	Issyk-Ata	2
	Moskva	1
	Panfilov	2
	Kemin	2
	Subtotal Chui	***13***
Issyk-Kul Oblast	Oblast Merged Hospital	2
	Ton	3
	Tup	3
	Jete-Ogus	2
	Issyk-Kul	3
	Balukchi	3
	Aksu	2
	Subtotal Issyk-Kul	***18***
Total		**31**

3.2.2 Participants

Selection
246 people in 31 group sessions participated in the study. 198 were female, 48 male. 207 were treated under the co-payment policy. These included 16 patients who had also been treated under the previous system. 39 were treated only under the previous system, i.e. a total of 55 had experience under the previous system. 55 were treated in surgical departments (surgery, gynecology, and traumatology), 115 were mothers with deliveries, and 76 were treated in other non-surgical departments. For more detailed information on the distribution of participants see table 2.

The participants were identified in the following way. The team looked through discharge lists of patients in the selected hospitals and identified villages where at least 5 of recently discharge patients could be found. Then they went to this village and invited these patients to a session together with a number of people from that village who had been in hospital before the introduction of the co-payment policy. Thus experiences with both systems were present in the groups. In addition 16 patients knew both systems because they had been hospitalised under both systems. For three sessions this procedure was changed because the team was not given insight into the discharge list of one hospital. In this hospital the team conducted 3 sessions with patients present in the hospital, making sure that they were undisturbed and unobserved by staff.

The team conducted 8 sessions with 60 mothers specifically on issues of delivery. All of these had delivered under the co-payment policy. 4 of these sessions were conducted at hospitals and 4 in villages.

Time of data collection
October 6 – 14, and October 26 – 27, 2001

The team
Four facilitators were split into two teams of two with one man and one woman in each team. The facilitators have extensive experience in conducting qualitative investigations with PRA tools.

Pilot study
The study was pilot tested with people who had received treatment in 2 hospitals in Chui Oblast.

Table 2: Distribution among participants

a) Among all participants (n=246)

According to gender		According to payment system	
Male:	48	Hospitalised under co-payment policy:	207
Female:	198	Hospitalised under previous system:	39

Table a1: Distribution of all participants according to economic status

	Chui oblast	Issyk-Kul oblast	Total
Poor	45	97	142 (58%)
Middle	49	55	104 (42%)
Rich	-	-	0
Total	94	152	246

Table a2: Distribution of all participants according to location, departments and payment system

	Chui oblast		Issyk-Kul oblast		Total
	Hospitalized under		Hospitalized under		
Department	Co-payment policy	Previous system	Co-payment policy	Previous system	
Surgery, Traumatology, Gynecology	14	4	33	4	**55**
Therapy, Cardiology, Nephrology, Urology, Infections Diseases, ENT	14	13	37	9	**73**
Maternity	45	2	58	7	**112**
Pediatric department	1	-	5	-	**6**
Total	**74**	**19**	**133**	**20**	**246**

b) Among patients under co-payment policy (n=207)

Table b1: Distribution among patients under co-payment policy according to economic status

	Chui oblast	Issyk-Kul oblast	Total
Poor	32	87	119 (57 %)
Middle	42	46	88 (43%)
Rich	-	-	0
Total	74	133	207

According to insurance category		Among the insured were			
Uninsured	63	Deliveries (normal)	93	Exempted	27
Insured	183	Pensioners (not-exempt)	24	Farmers	5
		Employed	25	Students	1
		Children (>1 year)	9	Unemployed	0

Distribution among uninsured patients according to profession

Unemployed:	36
Farmers:	10
Deliveries before May 2001	12
Foreigners:	1

3.2.3 Methods

Six tools were used in the group sessions with people. Four visual instruments were designed according to PRA principles. Two more tools were verbal. They are described in the sequence in which they were applied in the sessions. Samples of the visual tools are shown in the appendix.

1. Focus Group discussions on awareness of participants on the co-payment policy.

2. A table with information on categories of patients according to diagnosis, insurance level, and payments made during the hospital stay. The team also categorised participants into 3 economic levels (rich, middle, poor) with the help of 3-4 simple questions such as main income source, debts, supporting children, pension level. This table served to understand whether people are paying actually what they should be paying according to the co-payment policy and whether this replaces other formal and informal payments ("Does it work?"). Beyond that this table provided a basis for further analysis by the people.

3. A scoring exercise that evaluated people's individual subjective perception of the following aspects of hospital treatment:

    - Availability of free drugs and treatment materials,
    - availability of free diagnostic procedures,
    - quality of food,
    - attitude of staff, and the
    - overall satisfaction with the hospital treatment

    Using different colours for those people who had been in hospital under the co-payment policy and those who had been treated before allowed comparing people's assessment of quality of service before and after introduction of the co-payment policy. This exercise was done with 23 groups.

4. A scoring exercise investigating people's individual assessments on the co-payment policy as a whole: People voted on the question, whether, if compared with the previous system, the new policy was overall better for them or worse or without change. Correlating these votes to the economic categories of the people allowed looking specifically how poor people perceive the new policy.

    In 8 sessions with 60 mothers who had recently delivered in hospitals we asked for a comparison of both policies specifically regarding deliveries. These groups were also asked to indicate the level of co-payment they thought adequate for deliveries, separately for normal and for pathological deliveries. For this they placed a dot on a scale between 0 and 600 Som.

5. Collecting case studies of people who needed to go to hospital but could not go because of the co-payment.

3.3 Workshop with health care practitioners from Central Rayon Hospitals

The objective of this workshop was to come to know the view of practitioners in peripheral hospitals on the co-payment policy.

Time and location

One-day workshop on October 22, 2001 in Bishkek.

3.3.1 Participants

24 heads of departments and nurses from six hospitals were invited. The selection of the hospitals was done randomly, as was the selection of the head of departments and chief nurses, within the frame of the following fixed conditions: both Oblasts were to be represented with three Central Rayon Hospitals, there were to be 8 heads of departments representing the operating disciplines (4 surgeons and 4 gynecologists), 8 heads of departments representing the non-operating disciplines (3 each from therapy and pediatrics, and 2 from infectious disease departments) and 8 chief nurses from all departments. Each hospital was to be represented by 4 people. With these preconditions hospitals and staff were then selected by a random process. The hospitals selected were Balukchi city hospital, Issikata CRH, Jete Ogus CRH, Kemin CRH, Issyk-Kul CRH, Panfilov CRH.

At the seminar 19 of the 24 selected staff members participated. Others could not come for various reasons. All selected hospitals were represented. There were 4 surgeons, 3 gynecologists, 2 pediatricians, 1 infectious disease physician, and 6 nurses.

3.3.2 Methods

The participants were split in three groups: doctors from operating disciplines (surgeons and gynecologists), doctors from non-operating disciplines (therapists, pediatricians, infectious disease specialists) and nurses from all disciplines. Three tools were used to address the following questions in the group work:

- Listing and prioritising the positive and negative aspects of the co-payment policy
- Comparing the co-payment policy with the previous system through individual voting on the following question: do you think the co-payment policy overall is better of worse than the previous system a) in regard to the quality of service for patients? b) for health personnel of the hospitals?
- Listing and prioritising recommendations to improve the co-payment policy

The participants were reassured not be afraid of voicing critique. They were informed that they had been chosen randomly, that they would work in the groups unobserved by the moderators of the workshop and that the groups would consist of members from different hospitals, so that the results of a group could not be traced to a specific hospital. In addition,

if participants had any comments they were afraid of saying openly they could write them on cards and put them into a closed ballot box ("black box").

3.4 Focus Group discussions with FGP staff

Focus Group discussions were held with staff from 9 FGPs in 4 Rayons. Their purpose was to assess whether the co-payment policy was a barrier to hospital treatment for poor people. Because the group sessions had been done mainly with people who had been in the hospital we wanted to use the FGPs' knowledge about those people who needed hospital treatment but never went to a hospital.

4. Results

4.1 Awareness about co-payment policy

The focus group discussions on awareness showed that most people know that a co-payment is requested now for hospital treatment even if they had not been in hospital under the co-payment policy. Most also know about their insurance status, but there remains considerable insecurity. Many pensioners do not know that they are insured because they do not have a paper about their insurance policy. Some farmers do not know how to get insured. Some unemployed people think they are still insured because they were under their last job. Among those who do know their insurance status few know how much they have to pay as co-payment. However, people are getting more and more interested in the details of it because they know that if they are insured they pay less than uninsured people. Overall the level of awareness seems to have increased since May.

4.2 Expenditures of patients treated under the co-payment policy

4.2.1 Co-payment

Figures in chapters 4.2 and 4.3 were established using the table described in the methodology chapter (3.3.2-1) that recorded individual accounts of patients about their expenditures. Almost all patients (96%) treated under the co-payment policy paid the correct amount of co-payment according to their insurance status. Only 8 patients paid an incorrect amount. 4 of them paid less than their due; in these cases staff seemed to have accepted less because of poverty of the patient. The 4 who paid more were: one pathological pregnancy (570 Som (vs. free of charge), one exempted patient paying 190 Som, one uninsured paying 1200 Som (vs. 1140 Som), and a normal delivery case paying 700 Som (vs. 190 Som due). All these cases were in different hospitals and departments, not suggesting a systematic mistake or wrongdoing.

4.2.2 Other payments

4.2.2.1 Contributions to the costs of treatment

59% (123) of patients paid nothing in addition to their co-payment or exempted status. 41% (84) did pay something in addition for their treatment; because some paid for more than one service the total amount of payments made was 122. The average amount of these additional costs amounted to 196 Som with a marked difference between Chui and Issyk-Kul (453 Som in Chui and 74 Som in Issyk-Kul). A small part of these payments were informal payments to staff (15, or 12%), while most of them (107, or 88%) were direct contributions to costs of treatment of the respective patient, mostly for drugs and diagnostic tests. The average of the additional expenses for treatment related costs was 132 Som. There was a considerable difference in the amount of additional payments between Chui oblast (319 Som) and Issyk-Kul oblast (57 Som). The distribution of the additional payments for treatments (except informal payments to staff) was as follows:

- 48 (24% of all patients) paid for **drugs and treatment material**, in average 250 Som (in Chui 461 Som, in Issyk-Kul 126 Som)

- 15 (7% of all patients) paid for **diagnostic procedures** an average of 33 Som

- 44 (21% of all patients) made contributions to hospital care **in kind** (notebooks etc), in average worth 32 Som (in Chui 80 Som, in Issyk-Kul 21 Som). (These in kind costs do not include costs for food brought from home; the study did not look at food costs).

4.2.2.2 Informal payments to staff

Informal payments to staff were defined for this study as payments to staff which staff explicitly asked for (not gifts out of gratitude). Overall 10 patients (5% of all patients under the co-payment policy) made 15 informal payments to staff (8 in Chui, 2 in Issyk-Kul). The average amount paid by these 10 patients was 403 Som (454 Som in Chui, 200 Som in Issyk-Kul). There seem to be two categories of such payments. One is obviously an informal salary to staff. But in some maternity departments patients are asked to contribute to the running/development of the facilities. This is more or less mandatory. In one department all mothers paid, suggesting some pressure. In another at least one mother refused and got treatment nonetheless Informal payments are more common and systematic in Chui oblast, whereas in Issyk-Kul they hardly exist. The details of these payments were:

- 4 payments were made into the pockets of staff (bribe)
- 5 payments were demanded for “discharge” in one maternity unit
- 6 payments were demanded as “contribution to the department”, all 6 in two different maternity units (mostly explained as a contribution to the neonatology unit)

The two cases in Issyk-Kul were made in two different hospitals. One was 300 Som to staff, the other 100 Som as contribution to the maternity department (this mother was asked to contribute something because she had a pathological delivery and thus did not made a co-payment). In Chui 8 patients paid an average of 454 Som (range 25 – 2000 Som). In one hospital there seem to be standard rates for gynecological operations (2000 Som) and surgical operations (500 Som). In another hospital all mothers in the maternity department

had to pay a "discharge fee" to staff (varying between 25-250 Som) and paid in addition to that a "contribution to the neonatology unit" of 100 Som each.

In summary, a majority of patients do pay something in addition to the co-payment; but almost all of these payments are made to cover direct treatment costs (88%). This may suggest that hospitals do not receive the required funds to cover the costs for all drugs, treatment material and diagnostic tests and ask patients to contribute what is missing. This was confirmed in the workshop with hospital staff. On the other side, informal payments to staff (bribery) is happening rarely (5% of all patients), although in certain hospitals systematically.

4.3 Comparison of expenditures in the old and new policy

Despite these additional payments the overall costs of hospital treatment for a patient seems to be much lower under the co-payment policy than under the previous system. The average cost per hospital stay under the co-payment policy was 491 Som in our sample, including the co-payment and all additional payments (the denominator for this average being all 207 patients treated under the co-payment policy, i.e. including the exempted categories who paid nothing). The average cost per hospital stay under the previous system was 1342 Som, about 2.5 times more (the denominator again being all patients treated under the previous system, including the exempted ones).

4.4 Quality of care

The numbers reproduced in this chapter (4.4) were established using the scoring exercise described in the methodology chapter (3.3.2-2). The study looked at four indicators of quality of care. Availability free of cost of drugs & treatment materials and diagnostic procedures, the quality of food, and staff attitude. In addition we assessed the overall satisfaction with the hospital stay. For each of these indicators a range of choices were given between all and nothing or very good and very bad. Participants indicated their answer by placing a coloured dot next to their choice. Patients under co-payment policy were given green dots, patients under the previous system were given red dots. This allowed comparing their votes. This exercise was done with 23 groups. The total number of votes varied because not all participants always participated in this exercise or voted on all questions and because those participants who were in hospitals under both systems voted for both. Because of the small number of patients with experience under the previous system (only 55 participants, often not all voting) their vote distribution must be viewed with caution. Nonetheless, the results show a clear tendency of patients' preferences. For all indicators participants gave the co-payment policy clearly better notes than the previous system.

4.4.1 Availability free of cost of drugs & treatment material

We asked the participants the following question: To what degree did you receive drugs and treatment material free of cost during your hospital stay: all, most, little, or nothing?

60% of patients under co-payment policy said that they received all drugs and treatment material free of cost, 8% said they received none. Compared with the previous system this is a clear improvement, where only 20% of our participants received all drugs and treatment

material and 43% none. As reported under 5.2.2.1, 24% of patients paid additionally for drugs and treatment material, meaning that 76% did not pay extra. There seems to be a contradiction to the 60% reported in this paragraph who said that they received all drugs free of cost. The reason for the difference is that the tool used to evaluate the quality of care parameters and the questions asked allowed for subjective voting on the *perception* of complete coverage with e.g. drugs. The fact that with this tool less patients said that they had received all drugs free of costs can be interpreted as meaning that there were a number of patients who felt they had not got all drugs they actually needed, but also were not asked to purchase additional drugs. And indeed, there were comments from patients about such perceptions. The same applies to the other differences of figures in this paragraph as compared with 4.2.2.1.

Table 3: Availability of drugs & treatment material

Received free of cost	Co-payment policy		Previous system	
all	87	*60%*	10	*20%*
much	26	*18%*	10	*20%*
little	20	*14%*	9	*18%*
nothing	12	*8%*	22	*43%*
Total	145	*100%*	51	*100%*

4.4.2 Availability free of cost of diagnostic tests

For diagnostic tests the difference between co-payment policy and previous system is less obvious. Still, 75% of patients received all tests free of cost under co-payment policy, compared with 56% under the previous system.

Table 4: Availability of diagnostic tests free of cost

Received free of cost	Co-payment policy		Previous system	
all	100	*75%*	23	*56%*
much	16	*12%*	8	*20%*
little	8	*6%*	4	*10%*
nothing	9	*7%*	6	*15%*
Total	133	*100%*	41	*100%*

4.4.3 Quality of food

Regarding food participants indicated an improvement under the co-payment policy. 78% said it was good or middle, vs. 22% bad or very bad. The respective percentages for the previous system are 44% vs. 56%.

Table 5: Quality of food

Quality of food	Co-payment policy		Previous system	
good	55	*40%*	4	*16%*
middle	54	*39%*	7	*28%*
bad	27	*19%*	10	*40%*
very bad	3	*2%*	4	*16%*
Total	139	*100%*	25	*100%*

4.4.4 Staff attitude

Staff attitude was always perceived to be good. But here also, participants expressed a slight improvement. 86% said it was very good or good under the co-payment policy, vs. 69% under the previous system.

Table 6: Staff attitude

Staff attitude	Co-payment policy		Previous system	
very good	2	*1%*	0	*0%*
good	116	*85%*	33	*69%*
middle	10	*7%*	11	*23%*
bad	8	*6%*	3	*6%*
very bad	0	*0%*	1	*2%*
Total	136	*100%*	48	*100%*

4.4.5 Overall satisfaction with hospital stay

Asked about their overall satisfaction with the hospital stay more participants were satisfied with their stay under the co-payment policy than under the previous system. 61% of patients under co-payment policy said it was good, vs. 19% bad or very bad. The respective figures for patients under the previous system are 38% good and 26% bad or very bad.

Table 7: Overall satisfaction with hospital stay

Overall satisfaction	Co-payment policy		Previous system	
very good	0	*0%*	0	*0%*
good	80	*61%*	16	*38%*
middle	27	*21%*	15	*36%*
bad	19	*15%*	10	*24%*
very bad	5	*4%*	1	*2%*
Total	131	*100%*	42	*100%*

4.5 Comparative assessment of old and new policy

4.5.1 All cases except deliveries

If asked to compare overall the co-payment policy with the previous system a majority of 70% of patients prefer the co-payment policy, versus 23% who think it is worse. 7% see no difference (of all 173 patients who voted, see table 8). A similar picture appears if one analyses only the votes of those patients who actually had experience under the co-payment policy (135 votes, 74% better, 9% equal, 17% worse). There is no marked difference in the assessment between patients from Chui and Issyk-Kul.

Table 8: Individual votes among all patients on the question: overall, do you think the co-payment policy is better, equal or worse than the previous system

	Votes of all patients (n=173)		
	Better	Equal	Worse
Chui (n=53)	37 (70%)	2 (4%)	14 (26%)
Issyk-Kul	84	10	26

(n=120)	(70%)	(8%)	(22%)
Total (n=173)	121 (70%)	12 (7%)	40 (23%)

The reasons given for judging the co-payment policy better than the previous system related almost all to the fact that with 570 Som treatment is much more affordable than before. Also, knowing in advance of what needs to be paid is helping in preparing the hospital stay. The other reason given very often was that now they do not have to go around and buy drugs and treatment material from pharmacies, as these are now mostly available in the hospital. Especially in emergency cases this allows for prompt and effective treatment.

Many of those who judged the co-payment policy to be worse than the previous system were uninsured. They argued that 1140 Som is a high amount difficult to arrange. Some said that the co-payment prevented them from going to a hospital.

If one looks only at those patients that were categorised as "poor" by the team again a similar picture emerges (see table 9), suggesting that even among poor patients a majority sees the co-payment policy as advantageous for them. However, among poor patients the difference among Chui and Issyk-Kul is considerable. Although the numbers were small for Chui (only 23 patients had been categorised as poor), it is striking that their votes were split about evenly between "better" and "worse". By contrast, in Issyk-Kul 74% of the poor patients perceived the co-payment policy better for them and only 17% as worse.

An explanation for this difference in perception between Chui and Issyk-Kul may lie in the difference in additional payments documented above. All 8 poor patients who had been in hospital under co-payment policy in Chui hospitals and who assessed it to be "worse" than the previous system had to pay additional fees to their co-payment in the range of 245 - 950 Som. In all cases this included informal payments to staff, ranging from 25 to 250 Som. By contrast, among those 11 poor patients in Chui who assessed the co-payment policy to be "better" than the previous system only two made additional payments to the co-payment, one for buying drugs (200 Som), the other as an informal payment to staff (100 Som). Furthermore, in Issyk-Kul, among the 8 poor patients who voted "worse" only 2 paid very small amounts for contributions in kind (20 and 30 Som, resp.). And among those 62 poor patients in Issyk-Kul who voted "better" none made any additional payments beyond the co-payment.

Table 9: Assessment by the poor: Individual votes among poor patients on the question: overall, do you think the co-payment policy is better, equal or worse than the previous system

	Votes of all poor patients (n=107)		
	Better	Equal	Worse
Chui (n=23)	11 (48%)	2 (9%)	10 (42%)
Issyk-Kul (n=84)	62 (74%)	8 (9%)	14 (17%)
Total (n=107)	73 (68%)	10 (9%)	24 (22%)

4.5.2 Deliveries

In 8 sessions 60 mothers compared both policies specifically regarding deliveries. The result is the opposite of the general perception. Only 27% of them regarded the co-payment policy as better, and 68% as worse than the previous system. The reason they gave was that the 570 Som co-payment for a normal delivery was too much. Discussion revealed that the resistance to co-payment for deliveries was lower than it had been in May when the rate was 1140 Som for a normal delivery. At that time also the rejection was complete[5], compared with a 27% positive vote now.

When asked about an adequate co-payment for normal deliveries about half (27) it should be free of cost and another half (30) placed their vote Somewhere between 100 and 300 Som (3 above 400 Som), (see figure 1).

But for pathological deliveries mothers seem to be ready to pay much more. More than half (35) thought that around 600 Som was adequate, one fourth (14) thought it should be free of cost, one fifth (11) said between 200 and 400 Som. (see figure 1).

All in all therefore a picture appears that is almost exactly reverse to the current practice where pathological deliveries are free of cost and normal deliveries are charged 570 Som.

Table 10: Adequate co-payment for normal and pathological deliveries (explanation see text)

For normal deliveries

No of dots n=60	**Dots as placed by mothers**	Co-payment level (Som)
1	□	600
		500
2	□□	400
11	□□□□□□□□ □□□	300
12	□□□□□□□□ □□□□	200
7	□□□□□□□	100
27	□□□□□□□□ □□□□□□□□ □□□□□ □□□□□□	0

For pathological deliveries

No of dots n=60	**Dots as placed by mothers**	Co-payment level (Som)
35	□□□□□□□□ □□□□□□□□ □□□□□□□□ □□□□□□□□ □□□	600
		500
1	□	400
7	□□□□□□□	300
3	□□□	200
		100
14	□□□□□□□□ □□□□□□	0

[5] Schüth, T. (2001). "People's Perspectives on the Co-payment Policy: Rapid Appraisal Study in the pilot area of Chui and Issyk-Kul Oblasts". Manas Health Policy Analysis Project, Policy Research Paper 8. Bishkek, Kyrgyzstan: World Health Organization and MOH.

4.6 Case studies regarding accessibility to hospital care

In each session participants were asked whether they knew of any patients in their village who needed to go to hospital but could not go because of the co-payment. A few such cases were told, among them mainly home deliveries. But people said also that a lot of newly identified brucellosis cases do not seek proper treatment because they cannot pay three times the admission fee for the three necessary hospital stays within a short time.

More frequent seem to be patients who go late to hospital because they either try to avoid hospitalisation and co-payment or are saving the money needed for co-payment. This phenomenon was mentioned by hospital staff, FGP staff and patient groups.

4.7 Focus Group discussions with FGP staff

We asked FGP staff about patients who needed to go to hospital but did not go because of the co-payment. Again, only very few such cases were mentioned. FGP staff said that for most very poor patients it is not a problem to get hospital care because a letter by the Ail Ökömötü certifying their inability to pay enables them to get free treatment.

In these focus group discussions FGP staff gave us other useful insights as well. They refer patients to hospitals explaining that they will have to pay only the fixed co-payment according to their insurance level. Afterwards patients often come back and complain that this is not true, that they had to bear additional costs as well. FGP staff feels that these additional payments beyond the co-payment discredit the co-payment policy.

Judging from the treatment cards of patients discharged from hospitals FGP staff has the impression that many patients do not receive all the drugs needed to treat their condition. If this is true it may be another indication that hospitals do not receive all needed resources for the treatment of patients.

Regarding deliveries FGP staff said that there are now less home deliveries than in the beginning of the co-payment policy. They think this is due to three reasons. First, with a co-payment of 570 Som the barrier is much lower now. Second, FGP staff prepares mothers now during pregnancy for the need to pay so that many families save something for that. And third, now in autumn people have more cash after the harvest. FGP staffs expect the number of home deliveries to rise again in springtime.

4.8 Workshop with hospital staff

4.8.1 Positive and negative aspects of the co-payment policy

The 19 hospital staff from 6 CRHs first listed in group work the positive and negative aspects of the co-payment policy and then ranked them according to their importance. On the positive side the main elements were better drug supply, better care for emergency cases, the possibility to exempt very poor patients from co-payments with help of the reserve fund and much less financial burden for surgical patients. As salaries have increased only very insignificantly this was not prominently mentioned as an improvement (see tables 11 and 12).

Table 11: positive aspects of the co-payment policy as seen by hospital staff

Rank	1 group (chiefs of surgical and gynecological departments)	2 group (chiefs of non-surgical departments	3 group (nurses of all departments)
1.	Improved drugs supply for emergency cases	Improved drugs supply, doctors decide about prescription, based on drugs available in hospital.	No need for patients to run around looking for drugs
2.	Diagnostic and lab tests are free of charge	Emergency care is provided free of charge	Availability of drugs for delivery of emergency care
3.	Reserve Fund allows treatment of very poor patients	Existence of exempted categories on co-payment	Improved food & supply with linen, mattresses, etc.
4.	Increase of salary, but insignificantly.	Reserve Fund allows treatment of very poor patients	Surgical patients are satisfied with low payment for surgical treatment
5.	Better food	Better food, better supply with linen, mattresses, etc. (but not in rural areas)	
6.	Co-payment policy is good for severe cases and surgical cases	Increased salary (insignificant, as hospitals earn little)	

As for the negative aspects the main complaints relate to insufficient or irregular supply with financial resources, concerns about an access barrier due to the co-payment and various limitations and pitfalls of the policy in practice (see table 12).

Table 12: negative aspects of the co-payment policy as seen by hospital staff

Rank	1 group (chiefs of surgical and gynecological departments)	2 group (chiefs of non-surgical departments	3 group (nurses of all departments)
1.	Unjustified financial penalties by MHIF lower the salaries affecting the morale of staff.	Low living standards of population and not all people can pay (especially in rural areas).	Undifferentiated level of co-payment and dissatisfaction of patients with non-severe cases. Lower accessibility of patients with infectious diseases. As result they stay at home and infect others.
2.	Against the rules, administration of hospitals takes over the function of the Treatment Control Commission regarding the use of the Reserve Fund.	Outdated infrastructure of hospitals	Insufficient drug supply
3.	Some patients leave without payment, doctors need to visit them at home in order to get payment	Exemption should cover children up to 3 years of age	Bulky documentation (especially for Reserve Fund)
4.	Essential Drug List is limited	There is no possibility to procure expensive drugs, as revenues collected are limited. We are cheating patients by prescribing the cheapest drugs in order to stretch resources.	Health personnel is not exempted from co-payment
5.	MHIF pays irregularly and incompletely	Decrease of hospital admissions	Decrease of hospital admissions
6.	Level of the overall salary is uncertain	Disparity between level of co-payment and expenditures for treatment	Bad food
7.	Health personnel is not exempted from co-payment	If number of very poor patients is high, then it is a loss for hospital, as	

Rank	1 group (chiefs of surgical and gynecological departments)	2 group (chiefs of non-surgical departments	3 group (nurses of all departments)
		Reserve Fund resources are limited.	
8.	Need for blood transfusion (and its cost) is not taken into account (before need for blood transfusion was met by relatives submitting blood when needed. Now patients think if they pay, then everything needed should be provided)	Low awareness of population about their rights and how to realise them.	
9.	It is bad that normal deliveries have to be paid for	There is no Reserve Fund for health personnel	
10.	Pathological deliveries should be paid for	Too much of paper work & checks, bulky record keeping (on co-payment, on MHI, on children, on adults)	
11.	In some hospitals no improvement of food	Irregular incoming flow of finances results in irregular supply with drugs	
12.	Payment demanded from foreigners is too high	Deduction from salaries of staff for patients who left hospitals without paying co-payment	
13.	Bulky documentation	No possibility to do secondary and tertiary preventive treatments (as many people do not have money to pay co-payment & there is no work of FGPs on secondary prevention)	
	14. Relationships with voluntary insurance companies are not defined	No work of FGPs with severe cases of patients, no preventive work	

4.8.2 Comparison with previous system

After this analysis staff made an overall assessment of the co-payment policy in comparison with the previous system a) regarding the quality of care for patients and b) in regard to their own situation as hospital staff. They were asked to place one individual card for each of these questions indicating whether the co-payment policy was better, equal to, or worse than the previous system. In addition, they were asked to write on the card why they voted as they did.

The results are a clear vote in favour of the co-payment policy. Regarding the quality of care 16 of 19 participants voted that the co-payment policy is an improvement over the previous system, 2 saw a worsening and 1 saw no difference. Regarding the situation of the health personnel 15 expressed an improvement, while 3 perceived a worsening (1 did not vote).

Regarding quality of care the main reasons staff gave for their positive comparison to the previous system were (in order of frequency):

- Improved supply of hospitals with drugs
- Better emergency care
- Diagnostic services free of charge
- Exempted categories get better care (drugs more available)

Those who saw a decrease in quality of care wrote that the co-payments leads to delayed hospital admissions or to no access at all to hospital care.

Regarding the situation of staff the main reasons they gave for their positive comparison to the previous system were (in order of frequency):

- Morale of staff is better because increased supply of drugs and diagnostics gives them the feeling to be able to serve the patients better; it also in an increase in respect from the patients.
- Increased salary (although mostly very small increase)

Those who perceived the situation of health personnel worse than before argued that that the methodology is not thoroughly worked out and that salary increase is insignificant.

4.8.3 Recommendations

We asked the staff to work out recommendations in their groups for improving the co-payment policy. The main recommendations are related to increase of salaries and improvement of drug supply to hospitals (see table 13).

Table 13: Major recommendations by staff for improvement of co-payment policy

Regarding the salaries staff compared their salary level with the salary of staff of government institutions, saying that for example a freshly graduated accountant after a six months training course receives around 3000 Som per month. But doctors and nurses after many years of study and specialisation only receive around 600 Som. This they regard as completely out of balance. In order to correct this they see the need for an increased share in the health sector budget of the country. Only staff from one hospital seem to receive presently a much improved salary (doctors about 1500 Som) due to health reforms. Staff from all other hospitals said they received minimally higher salaries than before.

Regarding the improved supply with drugs a number of concrete proposals were made (see table 13). Among the other recommendations one deserves special mentioning. Staff asks to not disturb them so much with countless numbers of visits by commissions. Staff said than, in addition to being a nuisance to normal work, that these commissions expect to be fed a good lunch. Because there is no budget item for that staff is asked to pay for it from their own pocket. They comply because they fear that otherwise these commissions will write bad reports.

Salary related

- Increase level of guaranteed salary to 2000-3000 SOM through increase of health sector budget by the government.
- Consolidate all sources salaries (budget, MHIF, co-payment) into one payment.
- Salary payment without delay
- Introduce exemptions for health personnel

Improvement of drug supply

- Merging all sources for drugs into one pool (MHIF, budget, co-payment and humanitarian aid)
- If not possible at least merging of drugs from MHIF for children and adults into one pool (less paper work and greater flexibility in use of drugs).
- Create a revolving fund in hospitals for continuous purchase of drugs independent of delays in payments from MHIF, budget, collection of co-payments etc.
- enable hospitals to buy drugs on credit
- MHIF should provide payments to hospitals promptly and fully
- Allowing usage of drugs from MHIF for non-insured patients because they have paid already 1140 SOM
- Allow to ask those patients, who are willing to do so, to buy drugs in addition to hospital supply if needed.

Related to efficiency

- Improve infrastructure of hospitals, including stationary, linen, blankets, mattresses, etc. (if only because people are paying now and expect proper service)
- Simplify documentation (paper work) (for example to have one list for per patient to register all drugs from different sources)
- Don't disturb work of staff through hundreds of visiting commissions. "We want to work normally and not for the commissions". "The commissions expect to get nice lunches for which we have to pay out of our own pocket, because otherwise they will write a bad report."

Related to co-payment level

- Co-payment level for normal deliveries should be very low
- There should also be a fee for pathological deliveries.

4.8.4 Black box

Many participants took the occasion and wrote comments on cards and put them anonymously into the black box. Table 14 lists all these comments which have not been reflected already in the recommendations above

Vote on staff reduction

Increasing the efficiency of hospitals in the frame of health care reform means also that hospitals have to reduce staff. Some chief doctors of Chui and Issyk-Kul oblasts have reported to the MoH that their staff instead has voted to accept about the same low salary as before in order to keep all staff in place. However, among the participants of the workshop nobody was ever asked this question although most continue to receive about the same low level of salary as before, with a minimal increase only. We therefore asked the participants to make a secret vote on this issue in the black box. The result shows that most would prefer to decrease staff if that would mean higher salary. Only 2 votes were for keeping the same number of staff, 7 votes for reducing staff for higher salaries. The other cards showed various formulations of the wish to increase salaries without reducing staff or without making a clear choice between the two. One comment wanted to make sure that any savings from cutting of staff is distributed among to operational staff, not among the bureaucrats of the hospitals.

Staff from the one hospital where staff was cut and the remaining staff receives much higher salaries commented that workload has been reorganised without a loss in quality of care.

Table 14: Comments by staff in the anonymous "Black Box"

Salary related

- Salaries to health personnel haven't been paid since July, but health personnel has to buy stationery, washing powder and soap for staff needs at the hospital.
- Heads of departments and Chief Nurses make doctors pay for patients who left hospital without paying co-payment.
- To revise salary rate for health personnel towards increase irrelevantly of availability of additional payments depending on performance (co-payment, MHIF). Otherwise if performance is low and plan is not met, then staff get only guaranteed level which is too low.

Related to specific patient groups and payment levels

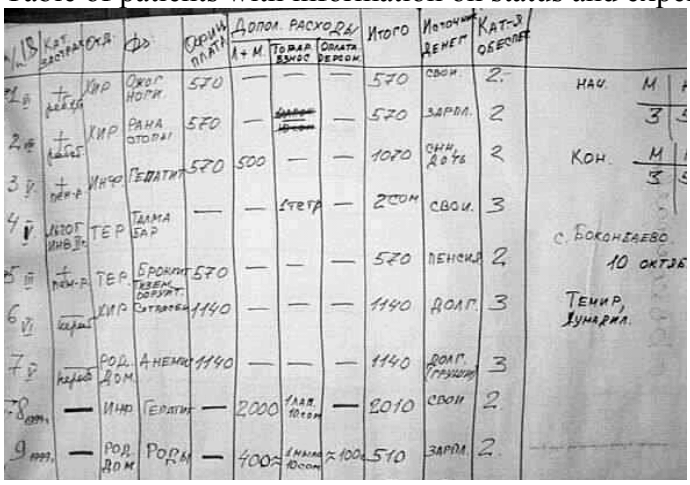
- To pay more attention to health care provided to children – drugs supply, provision of food, availability of hot water and improvement of conditions at the children departments.
- To make exemptions for patients with four infectious diseases (at least for children up to age 14 years old) to insure that they stay in hospital and do not infect others at home: – Viral hepatitis A, Gastroenterocolitis, Typhoid, Paratyphoid "A", severe cases of ARI
- To revise level of co-payment for elective cases (to make for example for children –190 Som);

General co-payment policy

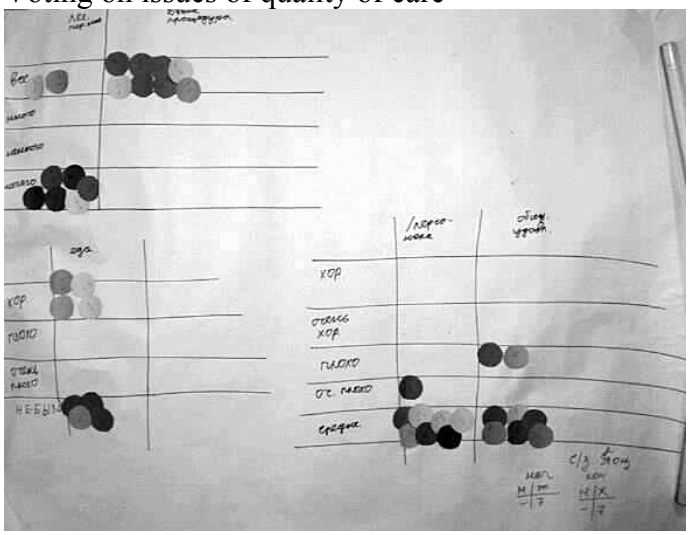
- There is a need to introduce co-payment policy in Bishkek in order to stop the bribery of doctors there.
- To introduce co-payment policy in the whole country.
- To ensure juridical protection of doctors.
- To implement a good work of FGPs on increasing awareness of population about reforms and co-payment policy.
- It should not be the doctors who are required to demand the co-payment from patients. Allow doctors to deal with patients only regarding treatment.
- There is already MHIF. What is the need in co-payment? Patients are suffering at home as not being able to pay co-payment
- At the beginning of Introduction of co-payment policy, there was Reserve Fund, later staff in our hospital was said that there is no any Reserve Fund.
- To increase the volume of humanitarian aid to hospitals

Appendix: Samples of PRA tools used

Table of patients with information on status and expenditures



Voting on issues of quality of care



Overall comparison between co-payment policy and previous system