REACHING THE POOR
WITH HEALTH SERVICES

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Kyrgyz Republic

Reducing Financial Burden of Health Care for the Poor—the Case of Kyrgyz Health Financing Reform

Motivation to Reform

In 2001, over 50% of health expenditures in the Kyrgyz Republic's health care system were raised through out-of-pocket payments (OOP), mostly associated with inpatient care and outpatient drug purchases. To obtain hospital care, patients had to contribute for medicines, syringes, IV tubes, bandages, linen, food, and even notebooks, light-bulbs, etc. This was in addition to informal payments to health care personnel. (Ibragimova 2001; Kutzin 2001) In 2001, the mean OOP was 1,846 soms (US$46) for those who reported any contact with the health system. This was equivalent to five times the average monthly per capita consumption raising questions of affordability for the large number of poor in the country.

The high share of out-of-pocket expenditures is a relatively new phenomenon in the Kyrgyz Republic that emerged in the post-independence transition period. Health services during Soviet times were free of charge except for the occasional gifts to health care workers and cost-sharing for heavily subsidized outpatient drugs. With the break-up of the Soviet Union and the general economic decline experienced during transition, public spending on health declined from 3.6% of GDP in 1991 to 1.9% by 2000. (Kutzin 2001) The extensive provider network built during the Soviet times absorbed an increasing share of declining government expenditures. Staff and utility consumed 75% of the health care budget leaving little resources for direct medical expenditures such as medicines and supplies. (Purvis, Seitalieva et al. 2005)

The Kyrgyz Health Financing Reforms (2001–2005)

The Kyrgyz Republic introduced far reaching health financing reforms in 2001–2005 as part of the ten-year Manas Health Sector Reform Program. Reducing the financial impact of out-of-pocket payments on poor households was one of the main objectives of the reforms. Given the limited fiscal space it was clear that the health sector will not have additional public funds to reduce patient expenditures. The large hospital sector had to be downsized in order to achieve efficiency gains and re-channel savings to medicines, medical supplies and better paid personnel in order to reduce out-of-pocket payments for these items.

The health financing reforms were based on a purchaser-provider split. The Mandatory Health Insurance Fund (MHIF) became purchaser of most individual health services and the Ministry of Health (MOH) remained purchaser of some individual health services (e.g. cancer services, tuberculosis) and public health services. The MOH also continued to assume functions of stewardship. The purchaser-provider split did not imply a change in the sources of funds only in the flow of funds and purchasing arrangements. The MHIF became a purchaser of health services using predominantly general tax revenues and a small payroll tax. The reforms were introduced in a phased manner starting with two oblasts (state) in 2001 and adding two oblasts per year until the reforms were rolled out completely by 2005.

The reforms consisted of four key building blocks:

- **Centralization of health financing channels (pooling).** Prior to the reforms, providers—nearly all public—were funded from general tax revenues corresponding to hierarchical administrative structures: republican level (federal) providers were funded from republican level taxes, oblast (state) facilities were funded from oblast taxes, and rayon (district) facilities were funded from rayon taxes. There was no funding and decision making across these

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administrative boundaries leading to duplication and lack of incentives for eliminating inefficiencies. The financing reforms centralized financing channels at the oblast level pooling tax revenues in the oblast departments of the MHIF. This move eliminated rayon and city level resource pools and created the opportunity to reallocate resources across city-rayon boundaries within oblasts.

- **Prospective purchasing methods.** Prior to the reforms, providers were paid based on input-based norms formulated into strict line-item budgets reflecting historical patterns. Managers could not re-allocate across line-item categories if need or the opportunity arose. In the context of the reforms, input based line-item budgets were replaced with capitation payment for primary care providers and case-based payment for hospital care.

- **Explicit definition of benefits.** The third step involved clear regulation of entitlements through the State Guaranteed Benefit Package (SGBP). The SGBP specifies free primary care for the entire population and referral care with formal co-payment. Co-payment is a flat fee payable upon admission. Exemptions were granted on the basis of certain disease categories which have high expected health care use such as disability, cancer, recently experienced heart attack, TB, etc. and for WWII veterans. Hospitals receive higher payment for treating exempt patients to prevent selection. Hospitals keep co-payment revenues and were mandated to use 80% of collected co-payments for the purchase of medicines, supplies and food.

- **Downsizing the hospital sector.** These changes in the health financing arrangements created an enabling environment to downsize excess hospital capacity. As most hospitals were built on a pavilion basis operating in 15–20 small buildings, within-facility downsizing had great potential for savings on fixed costs. The unnecessary buildings were demolished, rented out (e.g. to pharmacies), or transferred to other public use (e.g. health promotion units). During 2001–04, the physical capacity in the hospital sector was reduced from 1,464 buildings to 784 with a resultant change of the total operational area, utility costs and maintenance costs. At the same time, across-facility downsizing involved merging facilities serving overlapping populations through administrative mechanisms.

Reforms and the Financial Burden on Patients

The impact of the reforms on patient financial burden has been evaluated using two household surveys. The first one was conducted before the implementation of the reforms and the second one was conducted when the reforms had been rolled out to half of the oblasts but not yet to the other half.

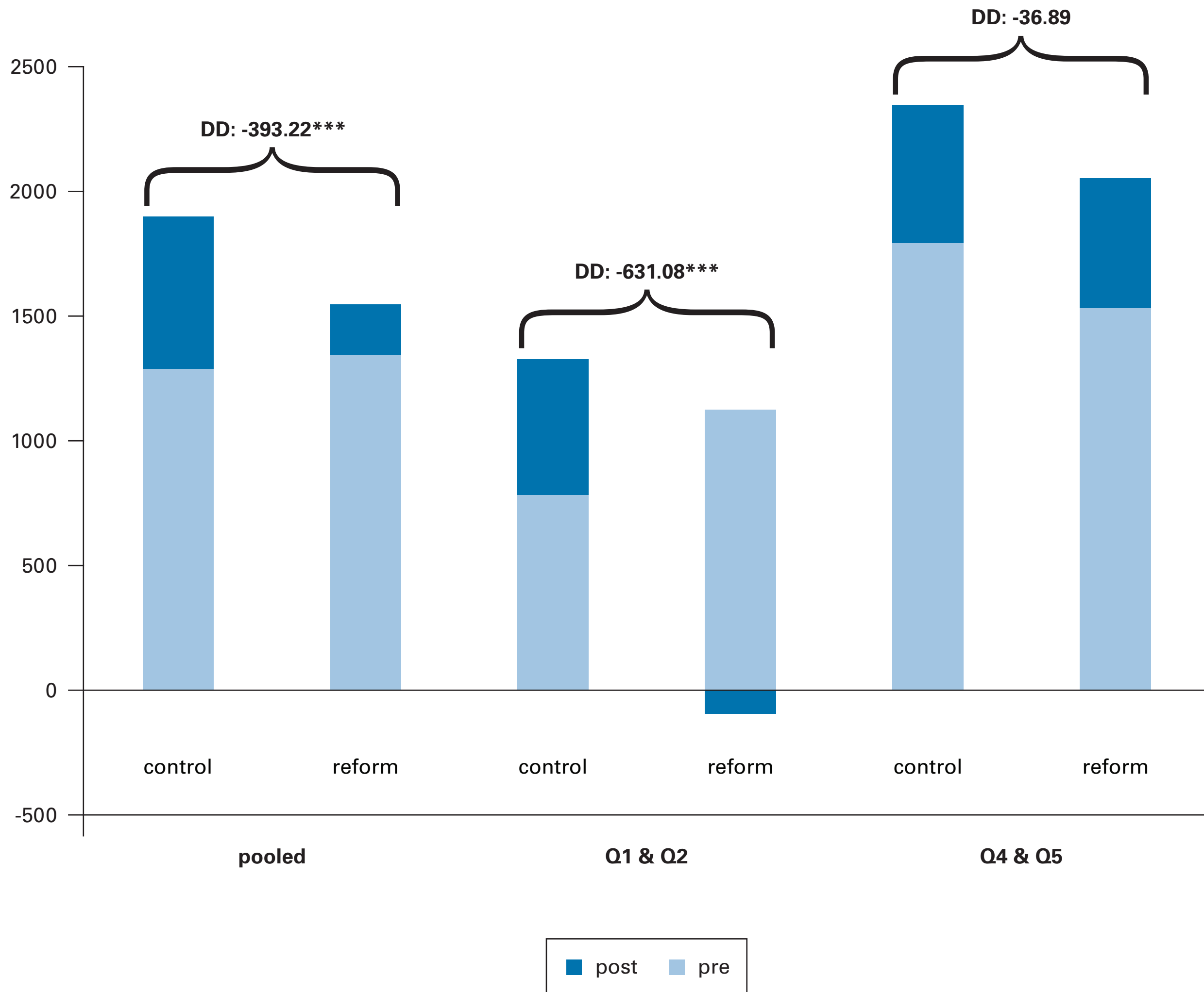
The evaluation finds that the reforms had a positive impact on patient financial burden for hospitalizations, particularly, for the poor. Out-of-pocket payments for hospital care increased significantly in control oblasts by nearly 600 soms (US$15). In contrast, out-of-pocket payments increased only by 200 soms (US$5) in the reform oblasts during the same period. Assuming that the reform oblasts would have experienced the same trends as control oblasts, the reforms were successful at limiting the increase in out-of-pocket payments for hospitalization by 393 soms (US$10) for an average household.

Figure 1 shows, the reforms had a greater impact on the lower income groups. Conditional on hospitalization, the poorest 40% experience a significant increase in their out-of-pocket payments in control oblasts while a slight decline in reform oblasts (Q1&Q2). In contrast, out-of-pocket payments increased both in the reform and non-reform oblasts for the richest 40% (Q4&Q5), indicating that the reforms neither slow nor increase the pace of growth in their out-of-pocket expenditures.

Analysis of secondary data is consistent with the explanation that the positive impact on financial protection was facilitated by greater efficiency gains in the oblasts where the financing reforms were implemented:

- Restructuring was more intensive in reform oblasts with 44% reduction in beds during the time period versus 18% in control oblasts
- Reduction in personnel by 28% in reform oblasts versus 24% in control oblasts
- There is also evidence that restructuring indeed allowed significant savings on utility expenditures estimated at 60% where restructuring took place
- In reform oblasts, non-medical expenditures (utilities and staff) in hospitals reduced from 83.6% in 2000 to 63.4% in 2003
- De-composed out of pocket payments shows a differential decline for medicines in hospitals

Figure 1. **Reform effect on hospital out-of-pocket payments conditional on hospitalization**



Note: Results are predicted values from a two-part multiple regression model of estimating the reform effect on individual health expenditures controlling for a number of individual, household, and regional characteristics. DD stands for difference-in-difference estimate and is the difference in the OOP trend between 2000 and 2003 in reform oblasts relative to control oblasts. (***) indicates that the DD estimate is statistically significant at the 1% level.

The study also highlighted that spill-over effects for visits and outpatient medicines took place at the same time. In reform oblasts, out-of-pocket payments for outpatient drug purchases and visits increased relative to control oblasts and reversed the protective effect the reforms exerted for hospitalization. This trend was stronger for the non-poor than for the poor. While this is a negative result from the perspective of financial protection, monthly out-of-pocket expenditures may have less catastrophic and impoverishing effects than large one-off expenditures incurred for hospitalization.

Conclusions

The Kyrgyz experience illustrates that limiting patient financial burden is possible in a poor country with limited fiscal space through more efficient use of public resources. This les-

son is particularly encouraging for other transition economies of the CIS (former Soviet republics) struggling with low levels of public financing and significant inefficiencies.

The Kyrgyz reforms involved the introduction of co-payments for hospitalization. Typically, the introduction of cost-sharing is associated with a negative impact on financial protection. The Kyrgyz experience shows when co-payment is introduced in an environment of high informal payments (to personnel but also for medicines and supplies), it is not necessarily associated with an increase in patient financial burden. Co-payment can create clarity and transparency in entitlements and can explicitly protect the poor through exemption schemes.

Finally, the Kyrgyz results also reinforce that there are no magic bullets to improving financial protection. The Kyrgyz experience was based on a complex systemic approach rather than on isolated reform instruments. Implementation of a complex systemic approach is quite challenging and requires longer time-frame and steady political support.

This brief is intended to summarize good practices in Health, Nutrition, and Population. It was edited by Melitta Jacab with support from WHO/EURO and based on "An empirical evaluation of the Kyrgyz health reform: does it work for the poor?" by Melitta Jakab, Harvard University/WHO (2007). The sources of information include those from Falkingham, Ibragimova, Kutzin, McKee, Mills, Preker, Purvis and Schuth. WHO also funded its data collection. The views expressed in this note do not necessarily reflect those of the World Bank.