



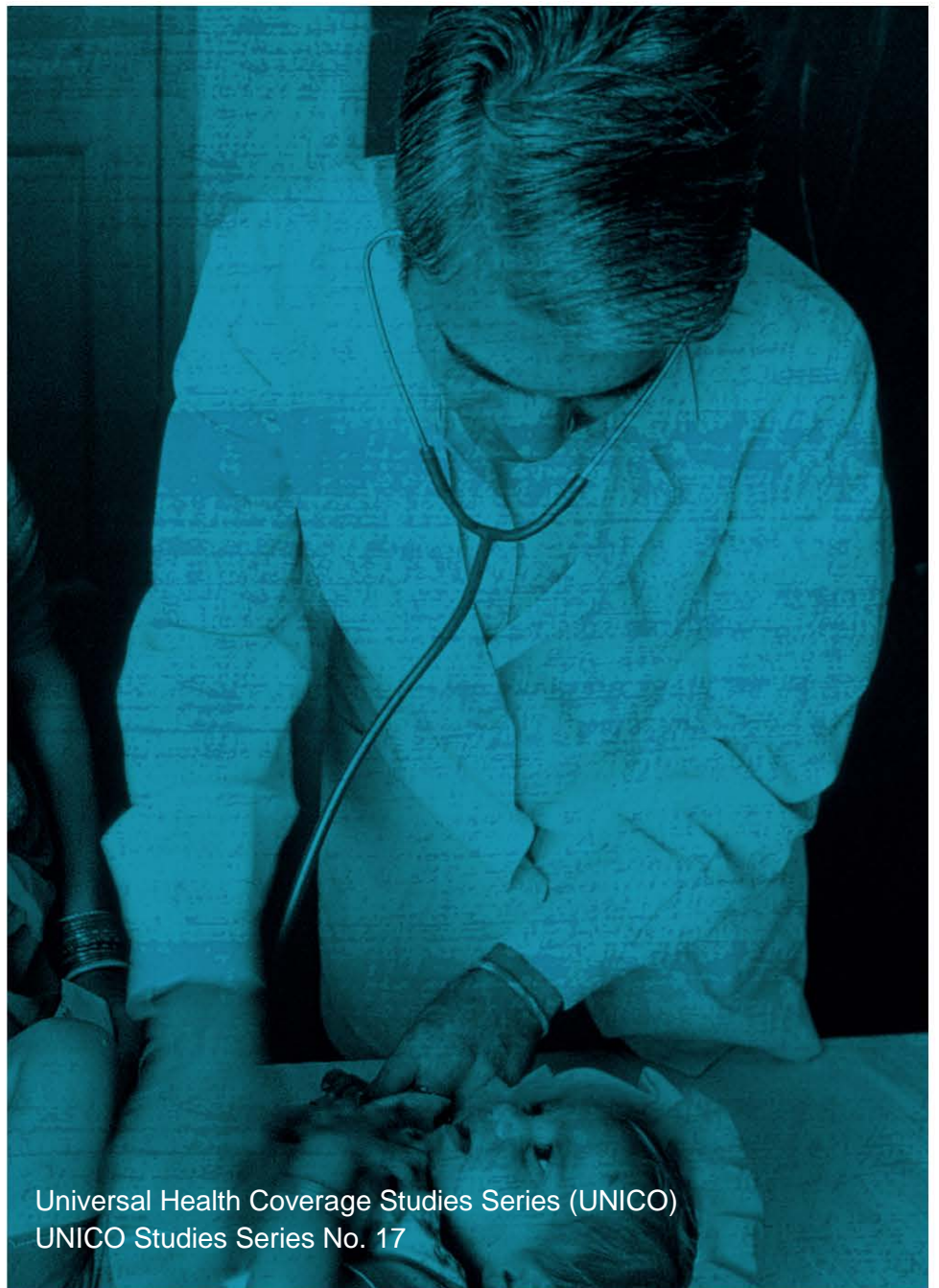
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# Toward Universal Coverage in Health:

## The Case of the State Guaranteed Benefit Package of the Kyrgyz Republic

Antonio Giuffrida,  
Melitta Jakab, and  
Elina M. Dale



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**UNICO Studies Series 17**  
**Toward Universal Coverage in Health:**  
**The Case of the State Guaranteed Benefit Package of**  
**the Kyrgyz Republic<sup>1</sup>**

Antonio Giuffrida, Melitta Jakab, and Elina M. Dale<sup>2</sup>

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<sup>2</sup> Antonio Giuffrida is with the World Bank, Melitta Jakab is with WHO-EURO, and Elina M. Dale is with the Johns Hopkins School of Public Health.

## **The World Bank’s Universal Health Coverage Studies Series (UNICO)**

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

Daniel Cotlear  
UNICO Studies Series Task Team Leader  
The World Bank  
Washington, DC

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## Abbreviations

ADP	Additional Drug Package
CVDs	cardio-vascular diseases
FAPS	Feldsher-Obstetrical Ambulatory Points
FGP	family group practices
FMCs	family medicine centers
GPC	General Practice Centers
MCH	mother and child health
MHI	mandatory health insurance
MHIF	Mandatory Health Insurance Fund
MOH	Ministry of Health
PHC	primary health care
SGBP	State Guaranteed Benefits Package
SSES	Department of State Sanitary-Epidemiological Surveillance
TB	tuberculosis

## Executive Summary

The Kyrgyz State Guaranteed Benefits Package (SGBP) represents a successful strategy to move toward universal health coverage in a low-income transition economy. The SGBP was introduced as part of a comprehensive national health reform program that included:

- Definition of health benefits in the SGBP, free primary care for all Kyrgyz citizens, and subsidized secondary care with extensive exemptions from copayments, which allowed maintaining equal access to basic health services.
- Introduction of a mandatory health insurance contribution financed through an earmarked payroll tax that increased public health funds and flexibility in their use.
- Creation of the Mandatory Health Insurance Fund (MHIF), which acts as the single purchaser of services provided under SGBP and which influenced provider behavior to desired actions.
- Pooling of all public funds including the general tax and payroll tax under the MHIF, which created economies of scale and lowered the administrative costs of managing the SGBP.
- Introduction of official copayments, which gave facilities small but vital amounts of cash for drugs and medical supplies, increased availability of medicines and supplies at the facility level, and reduced (informal) patient payments for these items.
- Introduction of population- and output-based payment mechanisms, which gave certain flexibility to facility managers and encouraged a more efficient use of resources.
- Organizational reforms that strengthened primary health care and supported the rationalization of the hospital care network, which led to significant efficiency gains, enabling a reduction of informal payments.

This approach has led to documented improvements in financial protection, access, and efficiency, and to the reduction of informal payments. However, some outcomes for key health conditions have not improved as much as expected, and quality of care remains a concern. To address these challenges, the *Den Sooluk* national health reform program for 2012–16 was developed. *Den Sooluk* focuses on four priority areas: cardiovascular diseases (CVDs), mother and child health (MCH), tuberculosis (TB), and HIV infection (HIV). *Den Sooluk* proposes an ambitious reform agenda that quantifies the health gains expected over the next four years, identifies the population and individual medical interventions required to achieve such health improvements, and spells out the health system strengthening activities required to achieve the desired goals.

In this case study we describe the evolution of the Kyrgyz health care system and discuss challenges in ensuring universal access to basic health care services. Section 1 provides an overview of the Kyrgyz health system and of the national health care reform programs that started in 2001 with *Manas* (2001–2005) and which have been continued with *Manas Taalimi* (2006–2011), and the recently adopted *Den Sooluk* (2012–2016). Section 2 provides a detailed discussion of the SGBP that follows a universal approach as it applies to all citizens, and describes the management of public funds and the information environment of the SGBP. Section 3 draws lessons from Kyrgyz national health reforms for universal health coverage for other countries with very limited public resources, widespread poverty, and high levels of

corruption. Section 4 discusses the remaining challenges for universal health coverage for the poor and how the provision of good-quality care forms an important part of the agenda for the recently adopted *Den Sooluk* program.



## Overview of the Kyrgyz Health System

The current health system in the Kyrgyz Republic has been gradually built over the last 20 years, since the collapse of the Soviet Union, and it has been evolving following the new political and economic realities.

The pre-1990s Kyrgyz health system adhered to the standard Soviet paradigm. The health system was centrally planned and managed, with minimum discretion allowed to local managers. The distribution of resources, number of hospital beds, and doctors per population followed the planning norms and standards developed by the Semashko Research Institute of Social Hygiene and Public Health in Moscow. The Soviet health system was highly inefficient, with a heavy emphasis on a large network of providers, a preference of hospital over primary care, and a focus on curative rather than preventive services. Health care was almost exclusively financed through state budgetary resources at several levels.

The input-based financing system contributed to the expansion of the physical capacity of the health delivery network and encouraged further inefficiencies. In addition, several line ministries, such as the Ministry of Defense and the Ministry of Interior, had their own health facilities. The financial sustainability of the Soviet Kyrgyz health system was possible thanks to substantial budget transfers and support of the national initiatives by Moscow (Rowland and Telyukov 1991). Notwithstanding its inefficiency, the Soviet health system made tangible progress in the Kyrgyz Republic. It provided universal access to basic health services and financial protection. It was also successful in fighting infectious diseases and improving key health outcomes (Meimanaliev 2003; Sargaldakova et al. 2000), although there is some disagreement about the extent of those achievements (Davis 2010).

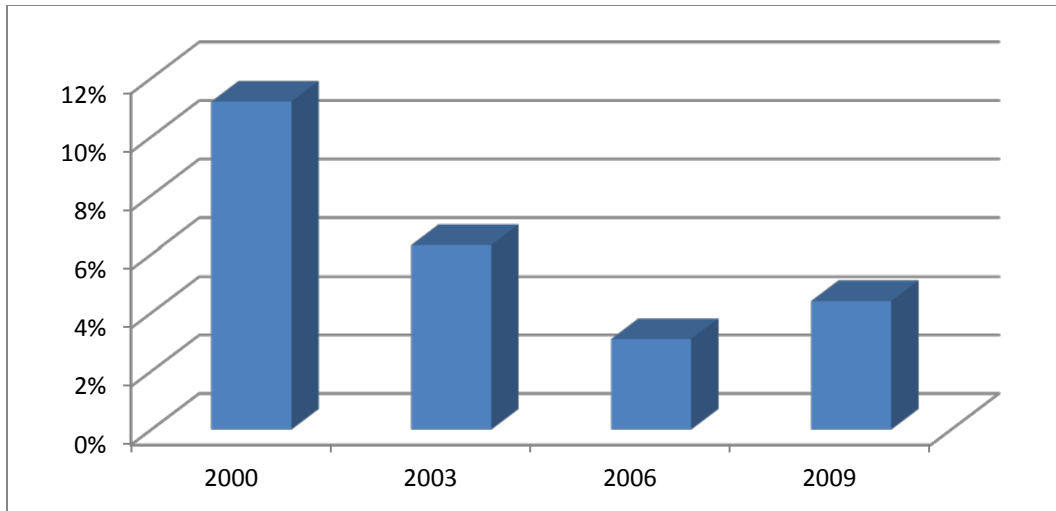
The Soviet model became unaffordable due to the deep economic crisis that accompanied the early years of the Kyrgyz Republic's transition from a Soviet Republic to an independent country. During 1991–95, while the breadth of coverage stayed the same, the depth of coverage eroded, as informal out-of-pocket payments became a usual practice (Jakab and Manjjeva 2008). The gap between de jure and de facto entitlements grew, resulting in a deep sense of disillusionment with the health system.

In this context, the *Manas* national health reform program was developed. The main objective of the *Manas* program, implemented during 2001–05, was to improve the financial sustainability of the health sector by restructuring the oversized and unaffordable hospital delivery network inherited from the Soviet period that was absorbing an increasing share of government resources. The *Manas* program was successful in reducing inefficiencies, and hospital capacity was reduced by 40 percent. The subsequent *Manas Taalimi* national health reform program, covering 2006–10, further strengthened health sector reforms, placing particular emphasis on reducing the financial burden on patients.

The results of the *Manas* and *Manas Taalimi* programs were mixed, however, but good progress was achieved on access and coverage, equity, financial protection, and efficiency.

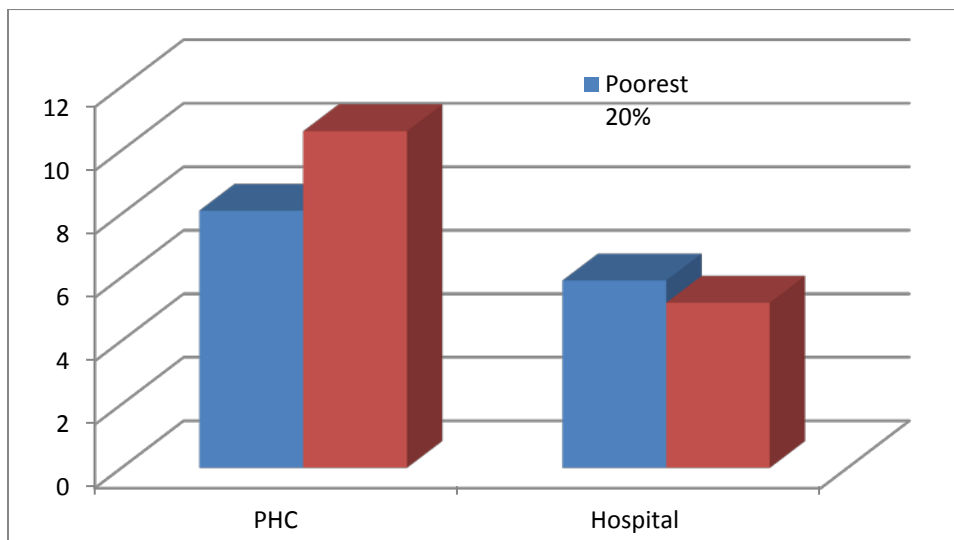
The barriers to access have been reduced in the last 10 years (see figure 1), and the Kyrgyz population enjoys higher coverage of a number of basic health services, such as immunization, prenatal services, contraceptive use, and skilled birth attendance compared to other low-income and low-middle-income countries (see Annex 1.III coverage comparisons). In addition, there is no significant utilization gap between the poor and the rich in either primary health care or hospital services (see figure 2).

**Figure 1 Percentage of Population that Needed but Did Not Seek Care Due to Distance or Affordability**



Source: Kyrgyz Integrated Household Survey, several years.

**Figure 2 Utilization of Primary and Hospital Health Care Services**

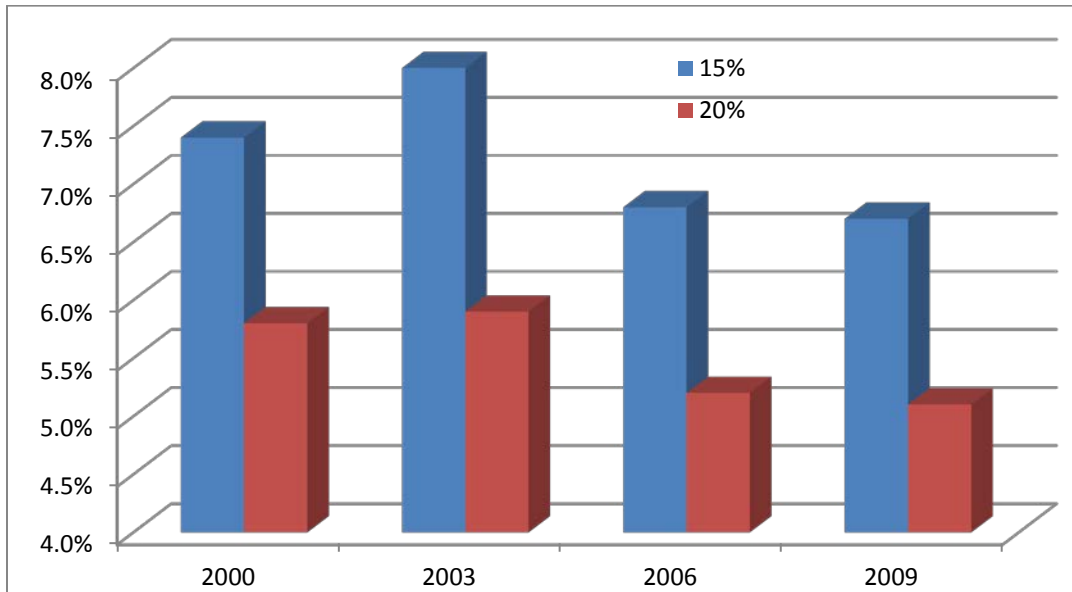


Source: Kyrgyz Integrated Household Survey, 2009.

The capacity of the health system to provide financial protection has improved over the last decade, as shown by the downward incidence of catastrophic health payments, which are defined as out-of-pocket health payments exceeding 15 or 20 percent of total household expenditure (see figure 3). However, in 2009 about 38 percent of households reported that it was “difficult” or

“very difficult” to afford health care costs. To find money to pay for health care costs, about 29 percent of households used savings, 25 percent reduced consumption, 13 percent sought support from relatives, 10 percent had to borrow money, about 9.5 percent sold production or animals, and about 2 percent sold other valuables.<sup>3</sup>

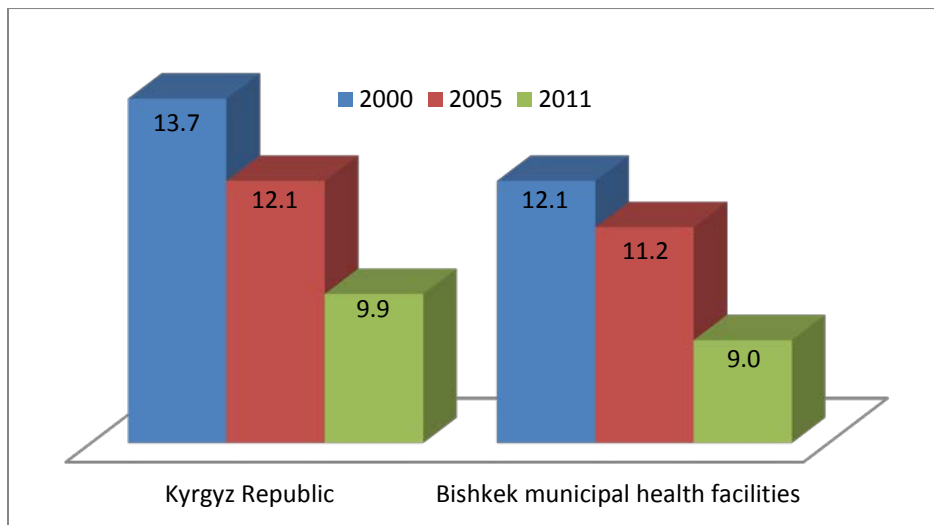
**Figure 3 Incidence of Catastrophic Payments**



Source: Kyrgyz Integrated Household Survey, several years.

With regard to efficiency, the average length of stay for hospital admissions has shown a strong downward trend both nationally and among Bishkek city health facilities (see figure 4).

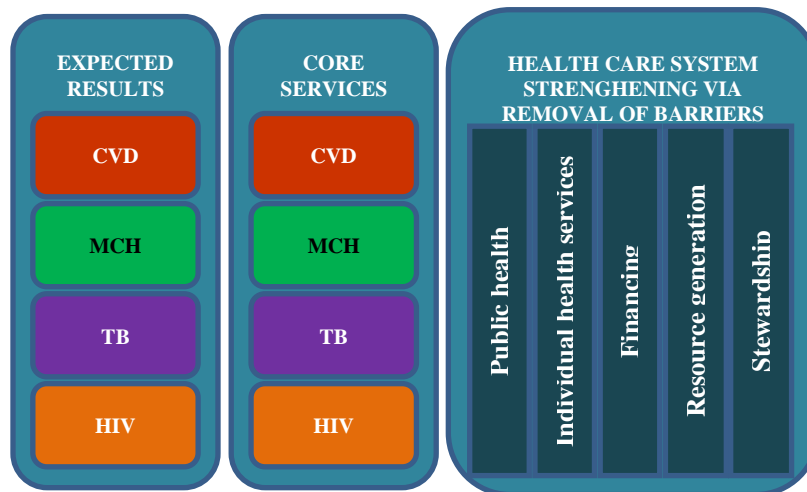
**Figure 4 Trend of Average Length of Stay, 2000–11**



<sup>3</sup> Kyrgyz Integrated Household Survey 2009.

Health outcomes for key conditions, however, have not improved, adult mortality is still high (see Annex 1.III outcomes comparisons), and quality of care remains a concern. These factors have led to dissatisfaction among the population and have undermined support of the public system. The *Den Sooluk* national health reform program, covering 2012–16, has been developed to address these challenges. The new program focuses on creating a strong link between program activities and their impact on health outcomes. Four priority health improvement areas have been selected for which expected gains in health outcomes have been set with a five-year horizon: cardiovascular diseases (CVDs), mother and child health (MCH), tuberculosis (TB), and HIV infection (HIV). The strategic approach of *Den Sooluk* is based on three interlinked pillars: (a) expected health gains, (b) core services needed to achieve expected health gains, and (c) detection and removal of health system barriers that undermine the delivery of core services and hence the achievement of health gains (see figure 5).

**Figure 5 Strategic Approach of the Den Sooluk National Health Reform Program**



For each health priority, the *Den Sooluk* program defines core services whose full delivery to the population is essential for the achievement of expected health improvements. Core services include population-based interventions and individual medical services that are evidence based and are feasible given the existing institutional arrangements.

The health care system strengthening dimension of the *Den Sooluk* focuses on the removal of those health system barriers that have undermined the delivery of core services needed to achieve health gains. Health system barriers have been identified for each of the four priority health improvement areas grouped around the main functions of health systems: public health, individual health services, financing, and resource generation and governance.

### Key Health Sector Reforms

The sequencing and step-by-step implementation were important elements of the success of the Kyrgyz Republic’s national health reform programs. The first phase of reforms rested on the following pillars (Jakab and Manjjeva 2008):

- Introduction of a mandatory health insurance (MHI) contribution, financed through an earmarked payroll tax to complement budget funds
- Replacement of line-item health financing with population- and output-based payment mechanisms
- Progressive centralization of the purchasing function under the Mandatory Health Insurance Fund (MHIF)
- Reforming of the health delivery system, development of the family medicine model for primary care, and restructuring of hospital care
- Clarification of entitlements and citizen obligations to copay through the introduction of the State Guaranteed Benefits Package (SGBP).

The payroll tax earmarked to health care was introduced in 1997 to attract additional resources to fund the sector.<sup>4</sup> The MHIF was created the same year to administer the new payroll tax. The MHIF began to contract providers and pay them based on new reimbursement procedures: case-based payment to hospitals and capitation-based payment to primary care level facilities. Therefore, even if the MHI contributions managed by the MHIF represented less than 4 percent of total health expenditure, they introduced important innovations in the system. During the first three years of reforms, the MHIF strengthened and developed its purchasing, operational, and institutional capacity.

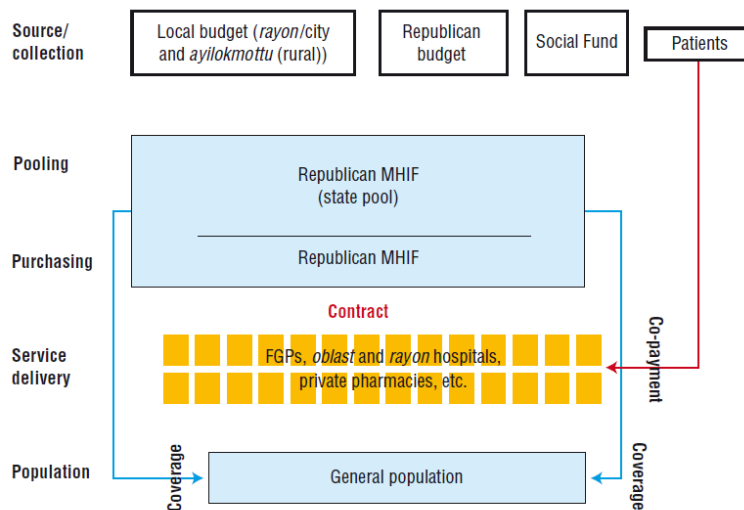
In 2000, the MHIF introduced the Additional Drug Package (ADP) on a pilot basis.<sup>5</sup> In 2001, the SGBP was introduced in pilot *oblasts* (region). Simultaneously, two *oblasts* started to pool budget funds and MHI contributions. The oblast pool was managed by the territorial MHIF that acted as a single payer using the new purchasing mechanisms for the entire pool of funds. In the meantime, health financing expert teams visited all health facilities, estimated the expected revenues under the new system, and made recommendations to optimize their capacity. Each year, two additional *oblasts* set up oblast-level health financing pools until the entire country was covered by 2005. In 2006, oblast pools were merged at the national level, allowing the MHIF to improve the geographic allocation of resources (see figure 6).

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<sup>4</sup> Contribution to MHI was set at 2 percent for the employed and is payable by employers. Farmers pay 5 percent of their land tax as their MHI contribution. Contributions on behalf of pensioners and the unemployed are made by the state budget and are calculated on a base equal to 1.5 times the minimum wage.

<sup>5</sup> Under the ADP program, the MHIF contracts pharmacies for the delivery of drugs included in the predetermined list. Pharmacies are reimbursed an agreed price that is based on the cost of the generic version of the drugs, and patients must pay the difference if the price charged by the pharmacy is higher.

**Figure 6 Pooling of Funds and Population Coverage**



Source: Kutzin, Ibraimova, Kadyrova, et al. 2002.

By the end of the *Manas* national health reform program, the MHIF was the single payer of the public health system, responsible for purchasing health services covered by the SGBP and the ADP. The MHIF consists of a central headquarters and regional (*oblast*) units. In addition to its main functions of managing contracts and administering payments to health providers, the MHIF is also responsible for monitoring the quality of health services and utilization and enrolment data, and for ensuring protection of patient rights (Government of the Kyrgyz Republic 2006; Ibraimova et al. 2011). Specifically, it is responsible for the following:

- Operating the hotline for complaints and inquiries
- Investigating complaints and ensuring that corrective measures are taken
- Conducting information and awareness campaigns on patient rights
- Working with civil society organizations on issues related to patient rights, particularly in the area of HIV/AIDS
- Coordination with other parts of the health care system for quality assurance measures
- Conducting regular patient satisfaction surveys.

The MOH is responsible for developing national health policy, preparing and implementing legislative acts, and implementing national health programs. It is also responsible for licensing medical and pharmaceutical activities, overseeing the accreditation of health care organizations, and the monitoring and evaluation of the health status of the population. The MOH also directly manages tertiary level facilities and is responsible for the provision of high-technology treatment.

The institutional relationship between the MOH and the MHIF has been evolving since its inception. The MHIF was initially established in 1997 as a fund directly accountable to the government, but in subsequent years it was transferred to the MOH. In December 2009, the MHIF was separated from the MOH and became directly subordinated to the Vice Prime Minister for Social Affairs.

## Health Financing Flow

The health sector of the Kyrgyz Republic is financed by public, private, and external funds (see table 1). Public funds are further subdivided into budget funds (state and local budgets) generated by general tax revenues and MHI contributions generated by the earmarked payroll tax. The predominant funding source is the general tax, and the payroll tax plays only a complementary role. Private out-of-pocket payments for health consist of copayments for services provided under the SGBP and ADP, informal payments charged by public providers, payment for drugs, and the premiums paid for private health insurance. External funds include grants from international organizations and donors provided either by inclusion in the state budget or through parallel financing (see table 1).

Between 2000 and 2010, with the exception of 2009, the share of private funds has exceeded the share of public funds in total health expenditures. In 2010, (the latest year for which full data are available), private funds represented 43.3 percent (about 86 percent of private health spending is out of pocket) of total health expenditures, public funds represented 43.9 percent, and external financing represented 12.8 percent (MHIF data based on NHA Report 2012, unpublished).

Around 70 percent of public funds are managed by the MHIF to purchase health services under the SGBP and the ADP (Temirov et al. 2011). The MHIF pools both general tax revenues and payroll tax funds in one pool and allocates it to providers.

**Table 1 Breakdown of Total Health Expenditure, Kyrgyz Republic, Selected Years, 2000–10**

	2000	2006	2007	2008	2009	2010
<b>In Nominal Terms</b>						
<b>Total health expenditures (million soms)</b>						
Budget (general taxation)	1,248.2	2,421.0	2,966.9	3,873.0	4,809.1	4,944.5
MHI contribution (payroll tax)	105.1	466.9	704.469	476.8	682.6	813.2
Private	1,521.4	3,921.9	4,398.4	4,823.2	5,356.6	5,671.7
External joint financing	N/A	252.6	529.7	409.1	943.2	823.5
External parallel financing	N/A	N/A	519.8	709.0	683.4	851.7
<b>Total</b>	<b>2,874.7</b>	<b>7,062.4</b>	<b>9,119.2</b>	<b>10,291.2</b>	<b>12,474.8</b>	<b>13,104.6</b>
<b>Per capita rate health expenditures (in soms)</b>						
Budget (general taxation)	255.0	466.5	567.9	734.1	894.1	912.6
MHI contribution (payroll tax)	21.5	90.0	134.9	90.4	126.9	150.1
Private	310.8	755.7	842.0	914.2	995.9	1,046.8
External joint financing	N/A	48.7	101.4	77.5	175.4	152.0
External parallel financing	N/A	N/A	99.5	134.4	127.1	157.2
<b>Total</b>	<b>587.3</b>	<b>1,360.8</b>	<b>1,745.6</b>	<b>1,950.5</b>	<b>2,319.3</b>	<b>2,418.6</b>
<b>As share of total health expenditures</b>						
Budget (general taxation)	43.4%	34.3%	32.5%	37.6%	38.6%	37.7%
MHI contribution (payroll tax)	3.7%	6.6%	7.7%	4.6%	5.5%	6.2%
Private	52.9%	55.5%	48.2%	46.9%	42.9%	43.3%
External joint financing	N/A	3.6%	5.8%	4.0%	7.6%	6.3%
External parallel financing	N/A	N/A	5.7%	6.9%	5.5%	6.5%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>As GDP share</b>						
Budget (general taxation)	1.9%	2.1%	2.1%	2.1%	2.4%	2.3%

	2000	2006	2007	2008	2009	2010
MHI contribution (payroll tax)	0.2%	0.4%	0.5%	0.3%	0.3%	0.4%
Private	2.3%	3.5%	3.1%	2.6%	2.7%	2.7%
External joint financing	N/A	0.2%	0.4%	0.2%	0.5%	0.4%
External parallel financing	N/A	N/A	0.4%	0.4%	0.3%	0.4%
<b>Total</b>	<b>4.4%</b>	<b>6.2%</b>	<b>6.5%</b>	<b>5.6%</b>	<b>6.4%</b>	<b>6.2%</b>
<b>In real terms (in prices of 2000)</b>						
<b>Total health expenditures (million soms)</b>						
Budget (general taxation)	1,248.2	1,876.5	2,086.7	2,187.9	2,543.8	2,421.7
MHI contribution (payroll tax)	105.1	361.9	495.5	269.3	361.0	398.3
Private	1,521.4	3,039.7	3,093.5	2,724.7	2,833.4	2,777.8
External joint financing	N/A	195.8	372.6	231.1	498.9	403.3
External parallel financing	N/A	N/A	365.6	400.6	361.5	417.1
<b>Total</b>	<b>2 874.7</b>	<b>5,473.8</b>	<b>6,413.8</b>	<b>5,813.7</b>	<b>6,598.6</b>	<b>6,418.3</b>
<b>Per capita rate health expenditures (in soms)</b>						
Budget (general taxation)	255.0	361.6	399.4	414.7	472.9	446.9
MHI contribution (payroll tax)	21.5	69.7	94.8	51.0	67.1	73.5
Private	310.8	585.7	592.2	516.4	526.8	512.7
External joint financing	N/A	37.7	71.3	43.8	92.8	74.4
External parallel financing	N/A	N/A	70.0	75.9	67.2	77.0
<b>Total</b>	<b>587.3</b>	<b>1,054.7</b>	<b>1,157.8</b>	<b>1,026.0</b>	<b>1,159.6</b>	<b>1,107.6</b>

Sources: Temirov et al. 2011; MHIF data based on NHA Report 2012, unpublished.

Note: To calculate health expenditures in real terms, the Consumer Price Index was used (2000 = 100).

## The Health Delivery System

The health services delivery system consists of three levels of care facilities. Primary health care (PHC) facilities comprise Feldsher-Obstetrical Ambulatory Points (FAPs), family group practices (FGPs), and family medicine centers (FMCs). FAPs provide PHC services in remote rural areas. They are usually staffed by at least one paramedic health worker, called a feldsher, but in larger villages, FAPs also employ a midwife and a nurse. FAPs offer the most basic services such as prenatal and postnatal care, immunizations, and health education (Ibraimova et al. 2011). FGPs are the main providers of PHC services and usually consist of three to five doctors. FMCs are the largest outpatient health facilities in the country. They employ 10 to 20 doctors providing primary and specialized outpatient services, as well as diagnostics and minor surgeries. Typically, there is one FMC per *rayon* (district) that is responsible for all FGPs and FAPs located in their catchment area (Ibraimova et al. 2011).

Secondary care is provided by oblast hospitals and territorial hospitals (former city- and rayon-level hospitals). Oblast hospitals have many medical departments and are able to treat more complex cases. In the Kyrgyz Republic, there are 41 territorial hospitals, including three children's hospitals and seven oblast hospitals (RMIC 2012). In addition, there are 27 General Practice Centers (GPCs), which provide both primary and secondary care (RMIC 2012). GPCs were formed in 2006 by merging territorial hospitals and PHC facilities in remote areas with populations of less than 25,000 (Murzalieva et al. 2007).

Tertiary level facilities consist of republican facilities (national hospitals and scientific research institutes and centers) and specialized dispensaries. These facilities are highly specialized and



provide services for specific diseases or conditions: cardiology, tuberculosis, traumatology and orthopedics, oncology and radiology, obstetrics, pediatrics, rehabilitation, treatment of infectious diseases, and treatment of mental illnesses (Ibraimova et al. 2011). All tertiary level facilities provide both specialized outpatient and inpatient services.

In addition, in the Kyrgyz Republic there are health facilities belonging to other ministries and agencies. The Ministry of Internal Affairs has 3 health facilities, the Ministry of Justice 19, the Ministry of Emergency Situations and the Ministry of Labor and Migration 1, the Ministry of Education 10, the Ministry of Defense 19, the National Security Service 2, the National Guard Service 1, and large state-owned enterprises 7 (Ibraimova et al. 2011). These health facilities are accountable to their respective agencies and are funded directly from their budget.

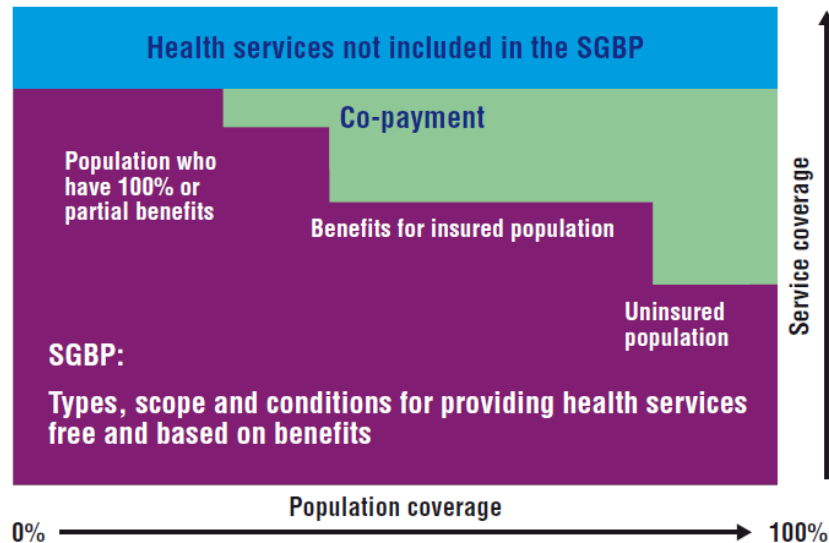
According to the law “On Health Protection of the Citizens of the Kyrgyz Republic,” approved in 1992, health services can be delivered by both private and public organizations (Meimanaliev et al. 2005). However, provision of publicly financed health services by private facilities is still very limited. Currently, legal mechanisms are not developed sufficiently to allow contracting of private providers under the SGBP. According to current budget procedures, state budget funds cannot be used to purchase medical services from private providers (MOH 2008).

Still, the number of private facilities operating in the country has been growing gradually since its independence. It started with pharmacies and later expanded to other health facilities. Although there are no accurate recent data on the relative size of the private sector, it is estimated that in the Kyrgyz Republic operates more than 2,500 private pharmacies and 40 private organizations licensed to conduct business in the pharmaceutical sector (National Statistics Committee 2009). Besides the pharmaceutical sector, more than 600 independent medical doctors and about 230 private health facilities were registered (Checheybaev et al. 2008). The private sector includes about 350 secondary level hospital beds, more than half of which are located in Bishkek, the capital. Finally, the private health insurance market is limited to a few small companies specialized in the provision of services for those people who travel abroad (Ibraimova et al. 2011).

### **The State-guaranteed Benefits Package**

The SGBP regulates the rights and obligations of citizens and the government with regard to the provision of health services. It establishes a predictable and transparent system of entitlements that is revised annually by government decree (Manjjeva et al. 2007). The SGBP follows a universal approach as it applies to all citizens and defines a basic package of health services that is publicly funded and made available to the entire population. Primary health care and emergency care are provided free of charge to all citizens. Referral care is provided for a flat copayment, with generous exemption categories (see figure 7).

**Figure 7 Population and Service Coverage under the SGBP**



Source: Kutzin et al. 2002.

### Entitlements of the SGBP

The SGBP provides free primary and emergency care services to the entire population. To receive primary care, patients must enroll with an FGP<sup>6</sup> and seek care in their place of enrolment. However, they are allowed to change FGP freely, and, unlike under the Soviet system, the FGP need not be where the permanent residence permit is registered. Lack of a clear understanding of this latter rule has created problems among the growing number of internal migrants, who believe that they are not entitled to seek primary care until they receive permanent residence in their new location, which often takes years. Temporary residence and identification documents are still required for enrolment, however, and these can also serve as barriers for access among the internal migrants, who often lack these basic documents (MOH 2008).

Inpatient and specialized outpatient care are provided with appropriate referrals, but with copayments. Copayments are defined as flat lump-sum payments made upon admission. The level of copayment varies across oblasts, by insurance status, by exemption status, and presentation of a referral slip from a primary care physician. Although enrolment with the MHIF is mandatory, as in many low-income countries, this is inappropriately enforced and enrolment is about 70 percent. The uninsured 30 percent are required to pay a higher copayment at the hospital level, providing incentives for enrolment and contribution payment. The level of copayment for hospital care is the only difference between the insured and the uninsured, since they all receive services in the same facilities. Those who are not formally employed or self-employed can purchase insurance in the MHIF. The annual cost of the insurance policy for 2011 was 400 Kyrgyz soms, or approximately US\$10 dollars.

<sup>6</sup> Patients belonging to vulnerable social categories (for example, World War II veterans or children under five) are automatically enrolled and are only required to show an ID supporting their status.

Exempt categories (see below) pay no copayment or pay a reduced copayment. In addition, to enjoy reduced copayment for inpatient and specialized outpatient care, patients must provide a valid referral from a primary physician in an FGP. Without a proper referral, a patient must pay the full cost of the services, regardless of their insurance status. This mechanism is intended to encourage greater utilization of primary care.

The SGBP defines the following caps on the benefits provided:

- The first type of cap is for number of hospital stays—two per calendar year—for social categories that are fully exempt from copayments. Once a patient exceeds this cap, he or she has to pay a copayment.<sup>7</sup>
- The second type of cap is on drugs provided per hospital stay. If the cost of medicine per beneficiary exceeds three times the average cost of treatment (approved by the MHIF), then the expert committee of the hospital can decide whether any further cost of treatment should be covered by the patient.
- The third type of cap is for the total amount of medicine per year per beneficiary that is provided under the ADP. This depends on type of medicine and disease and are listed in the government decree on the SGBP for 2011.<sup>8</sup>

High-technology (expensive) services are generally excluded from the SGBP, and patients requiring such services should join specific waiting lists. Provision is approved on a case-by-case basis by a special committee of experts. Drug benefits provided by the ADP are available only to citizens enrolled in the MHI and in an FGP. Only cancer patients can receive ADP benefits, as long as they have an identification card.

Modification of SGBP entitlement should take into account fiscal impact. However, in practice it has been modified under political pressure and without due consideration of the fiscal impact of the expansion of entitlements. An example is the expansion of exemptions introduced in 2006 to include all deliveries, children between 1 and 5 years of age, and pensioners 75 years or older, who were not covered by an increase in the available budget. The way the SGBP appears to be still within the budget is by (a) decreasing the existing financing norms, for example, for food per patient; (b) moving expenditures from one category to another; or (c) going into arrears, particularly in the payment of utilities.

The initial cost of the SGBP was mainly determined by an amount the government was willing to spend, although parts of the costs were based on actuarial studies. The main purpose was to equalize funding across the regions for the same type of services within the available resources (Manjjeva et al. 2007). Taking the existing budget as a given, costs of services were estimated based on existing norms. For example, at the hospital level it was decided that expenditures for food and medicine had to be equalized across regions and brought up to the level of Bishkek (the capital), which was the only region that followed the recommended norms for these items. These were the “costs” for food and medicine under the SGBP and formed part of the total cost of the SGBP.

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<sup>7</sup> The cap on the number of hospital stays per year does not apply to exempt disease categories or to children under five, who are fully exempt from copayments.

<sup>8</sup> For example, Ketoprofen for terminal stage cancer patients is capped at 3,600 milligrams per year per patient.

The methodology for estimating financing needs for the SGBP was developed and officially adopted in 2005.<sup>9</sup> A detailed study evaluating the medium-term financial sustainability of the SGBP was performed in 2006. It estimated a funding gap of around 20 to 27 percent of the total cost of the SGBP (Manjjeva et al. 2007).

### **Copayment Exemptions**

The SGBP entitles vulnerable groups to copayment exemptions. In addition, the SGBP protects the poor indirectly by bringing predictability and transparency to the statutory system of health entitlements and through a system that encourages preventive care and the creation of a nationwide pool that allows for geographic cross-subsidization.

Two types of targeting for copayment exemptions are used in the SGBP (Jakab and Manjjeva 2008):

- *Targeting based on social categories*, which is aimed at reaching economically vulnerable groups, defined largely in terms of social and demographic characteristics, such as World War II veterans, children under five years of age, pensioners 75 years or older, victims of the events of 2010 and their families, and the disabled regardless of their income.
- *Targeting based on medical condition and disease*, aimed at protecting those with expected high use of health care services (including pregnant women, terminal stage cancer patients, those with type I and type II diabetes, and those with hemophilia) and preventing the spread of and curing diseases with important public health consequences and externalities (including TB, AIDS, syphilis, anthrax, polio, and diphtheria).

The copayment exemptions are not targeted well to the poor population. A recent study shows that 50 percent of the poorest quintile and 39 percent of the richest are entitled to copayment exemptions (Jamal and Jakab 2013). There is significant undercoverage of the poor and leakage to the nonpoor. The exemptions work in the sense that the exempt have a significantly lower total financial burden given hospitalization than the nonexempt. Discussions are under way on how to improve the copayment policy and the targeting outcome of the exemption mechanisms to better protect the poor.

In addition, **patients from low-income groups** have the right to copayment exemption.<sup>10</sup> However, whether a particular patient is exempt is decided on a case-by-case basis by an individual facility committee, since mechanisms for this exemption are not well defined. If an exemption is granted, the costs are covered by the reserve fund of health organizations that are financed by setting aside 10 percent of all copayments received (Jakab and Manjjeva 2008). In addition, the process of obtaining documents certifying the patient as having an income below the poverty threshold is not a clear. Thus, while there is a national poverty threshold, only a few social assistance benefits are poverty targeted (for example, the Monthly Benefit for Poor Families), and there is no national registry of people entitled to social assistance benefits.

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<sup>9</sup> Government Decree # 280, July 1, 2005.

<sup>10</sup> Article 4, paragraph 23, Government Decree #350 on the SGBP, July 1, 2011.

## Management of Public Funds in SGBP

The MHIF, like all state entities, is subject to regular audit by the Kyrgyz audit authorities and is accountable to the Ministry of Finance for the use of public funds. In addition, to improve its transparency and accountability, the MHIF has created an internal audit unit, one of the first in the country. Finally, since the MHIF receives resources from the International Development Association (IDA), it is subject to external audit in accordance with international standards.

The SGBP is financed by four sources: the budget, the MHI payroll contribution, patient copayments, and special means. Each of these sources has different spending rules and flexibility. According to Article 34 of the law on health care organizations, health care organizations working under the single-payer system can “independently formulate...and make changes to the approved expenditure plan.”<sup>11</sup> However, existing financing regulations and guidelines, including those used by the Kyrgyz Chamber of Accounts in auditing public health facilities, limit the capacity for changing the approved expenditure plan. Moreover, in reality, MHIF budget funds are largely used to finance wages, which are a protected item, thus making budget funds rigid, with little room for managerial authority to move funds across different line items, to reinvest savings from efficiency gains, or to introduce incentives for health staff.

The persistent funding gap in the SGBP weakens the effectiveness of strategic purchasing in the sector. The MHIF contracts with health care providers on an annual basis. Contracts specify the expected volume of services for a given year, the total amount to be paid by the MHIF for these services, and the sanctions for exceeding the value of the contract. However, it appears that demand has often exceeded the number of patients or cases specified in contracts, which led to increased and unplanned expenditure for providers. As a result, hospitals have accumulated arrears, particularly for utilities and medical supplies. While it is possible for the MHIF to terminate the agreement if a provider does not meet the contractual obligations, the MHIF has not implemented such measures with public sector providers. This has weakened the effectiveness and value of contracts (Kutzin et al. 2002).

Another concern related to the management of public funds raised in the health sector fiduciary assessment (World Bank 2005) is the possibility of ghost patients. According to the assessment, there is no comprehensive system for the registration of patients, which makes it possible for them to appear in more than one FGP or FMC count (World Bank 2005). However, there are ongoing efforts to introduce an enrolment database for primary care that would eliminate this risk.

With the strengthening of the managerial and financial autonomy of providers, including the transition from line-item budgets to consolidated budgets, the responsibility of providers would also increase. Capacity building of health care providers, particularly in financial management, is one of the key priorities of the new *Den Sooluk* national health reforms program. A number of providers would become financially sustainable if they were allowed to adjust their structure, staffing, and overall allocation of financial resources (Ibraimova et al. 2011). However, regardless of efficiency gains, some facilities in remote areas might still be financially unsustainable, and new adjustment payment mechanisms are being developed and tried for them.

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<sup>11</sup> Law on Health Care Organizations in the Kyrgyz Republic, August 13, 2004, No. 116.

## The SGBP Information Environment

Monitoring and evaluation is conducted through a health information system consisting of five databases: the MHIF database on the insured population, the enrolment database that enables primary care facilities to make capitation-based payments, the hospital admission database with case coding that enables case-based payments, the outpatient care utilization registry, and the ADP database.

The MHIF information system tracks utilization of health services and copayments made under the SGBP by type of condition, social category, and geographic area. These databases play an important role in monitoring SGBP. Based on the routine analysis of payment and utilization data, the MHIF does the following:

- *Examines the outliers*, that is, facilities that have unusually low or high volume of reported copayments against the reported cases and conducts inquiries in cases where there is incongruence between reported cases and copayments. For example, if a case in a certain diagnosis-related group should have a certain level of copayment but the reported copayment is much higher, there is an inquiry, and depending on the outcome, further actions are taken.
- *Identifies barriers to utilization*. For example, if the utilization of child health services has decreased in a certain geographic area or facility compared to other comparable facilities or to the previous period, the MHIF quality control unit will examine this facility more closely by sending its experts to that facility for random checks, to review documentation, and to interview patients (for example, utilization may be falling because of informal payments).
- *Forecasts income for the next year*. Since copayments are an important source of financing, the information on the previous year's volume of copayment is used in budget preparation.
- *Estimates expenditures for next year*. Since hospitals are paid for the number of cases and payments depend on the case mix, the data are also used in predicting the "needs" or the required budget.
- *Examines the impact of new policies*, such as the abolishment of copayments for deliveries, on the budget of health facilities and sustainability of the SGBP.

In addition, the MHIF introduced a set of process indicators as part of its contracts with health facilities under the SGBP that includes growth monitoring and routine prophylactic of children under five, timely vaccination of children in accordance with the immunization program, timely provision of prenatal care, and follow-up of patients with primary-care-sensitive conditions (such as asthma, hypertension, and chronic obstructive pulmonary disease).

## Lessons for Universal Health Coverage

The SGBP represents a successful strategy to provide universal health coverage in a low-income transition economy. The SGBP was introduced as part of the comprehensive national health reform program, *Manas*, implemented during 1996–2006. Key aspects of the strategy included:

- Definition of a free basic health package provided for the entire Kyrgyz population, which allowed maintaining equal access to basic health services
- Introduction of an MHI contribution financed through earmarked payroll contributions, which increased public health funds and increased flexibility in the use of public resources
- Creation of the MHIF, which acted as the single payer of the services provided under the SGBP
- Pooling of all public funds under the MHIF, which created economies of scale and lowered the administrative costs of managing the SGBP
- Introduction of official copayments, which gave facilities small but vital amounts of cash that could be spent on drugs and medical supplies
- Introduction of output-based payment mechanisms, which gave certain flexibility to facility managers and encouraged a more efficient use of resources
- Organizational reforms, which strengthened PHC and supported the rationalization of the hospital care network.

This complex systemic strategy has been successful in improving health system performance in a number of areas.

- *Financial protection and access.* The financial burden on the poorest 40 percent declined significantly during 2001–06, the incidence of catastrophic payments was reduced, and geographic and financial barriers to access declined. While 11 percent of those who needed care did not seek it due to financial reasons or distance in 2000, only 3.1 percent reported the same in 2006 (Jakab 2013). These improvements occurred in the aftermath of the introduction of the single-payer system and the SGBP, with first oblast level and then national pooling, efficiency gains obtained from restructuring, and expansion of the SGBP.
- *Efficiency.* Efficiency of resource allocation within the SGBP improved. The share of health expenditures in the SGBP allocated to more cost-effective primary care increased from 29 percent in 2005 to 38 percent in 2009. This was the result of explicit budget allocation decisions at the MHIF, reflecting elements of strategic purchasing. Direct patient expenditures (drugs, supplies, and food) increased from 20 percent in 2005 to 30 percent in 2009 as a result of optimizing health facility infrastructure, and allowed a reduction of patient expenditures. The average length of stay for hospital admissions was reduced by about 28 percent nationally.
- *Transparency.* Between 2001 and 2006, informal payments for medicines and supplies significantly declined, which was a direct result of the efficiency gains noted above that led to the increased spending of public funds directly on patients rather than on infrastructure. However, informal payment to medical personnel continued to grow linked to very low salaries, with a widening gap between the salary level of medical personnel and the rest of the economy.

## **Pending Agenda**

Notwithstanding the increase in public health spending, the SGBP suffers a persistent funding gap, which is demonstrated by the declining but continuing practice of charging informal payments to patients.

In the last decade, there has been a considerable increase in the population categories entitled to various forms of exemption—from 29 categories in 2001 to 72 in 2012—which was in turn accompanied by an increase in the number of patients entitled to exemptions. The share of patients treated in hospitals eligible for either complete exemption from copayments or reduced copayments because of their socioeconomic status increased from 8.8 percent in 2003 to more than 50 percent in 2009. In 2009, 33.3 percent of patients in hospitals made no official payments, while 11.1 percent made reduced copayments, resulting in 44.4 percent exempted patients (MHIF 2010). The growing number of exempt patients increases the SGBP funding gap. In addition, the current mechanisms used to target copayment exemptions do not ensure that the poor are exempt.

A number of options have been discussed to reduce the SGBP funding gap.

First, and most important, in the limited fiscal context, is the implementation of additional efficiency measures. The restructuring agenda in Bishkek and Osh remains on the table, with the health care network and infrastructure largely untouched since independence, which has led to increasingly decaying facilities that cost more and more to maintain. This is also where informal payments are the highest. Further, hospitalization rates are high, as is overuse of medication. Addressing these factors could result in significant savings for the health sector, which then could be used for improving the quality of care for the population and reducing informal payments, and thus, the funding gap in the SGBP.

Second, it is important to improve the targeting of copayment exemptions and to better focus on the poor. In the revision of the copayment and exemption policies, it is desirable to create synergies with the instruments used to target social assistance benefits, such as the Monthly Benefit for Poor Families, if possible. In addition, the pooling of the reserve funds provided by health facilities and adoption of clear mechanisms for their utilization could increase transparency and access to health services by the poor.

Third, formal private financing could be increased. For example, the value of copayments has significantly eroded and has not kept pace with general inflation, and their increase could attract additional formal funds to the sector. Another option is to explore the feasibility of developing a market for Voluntary Health Insurance, which could supplement the coverage of the SGBP. In the Kyrgyz Republic, a supplementary Voluntary Health Insurance could offer improved access to health care covered by SGBP, including access to private providers that provide a greater level of amenities.

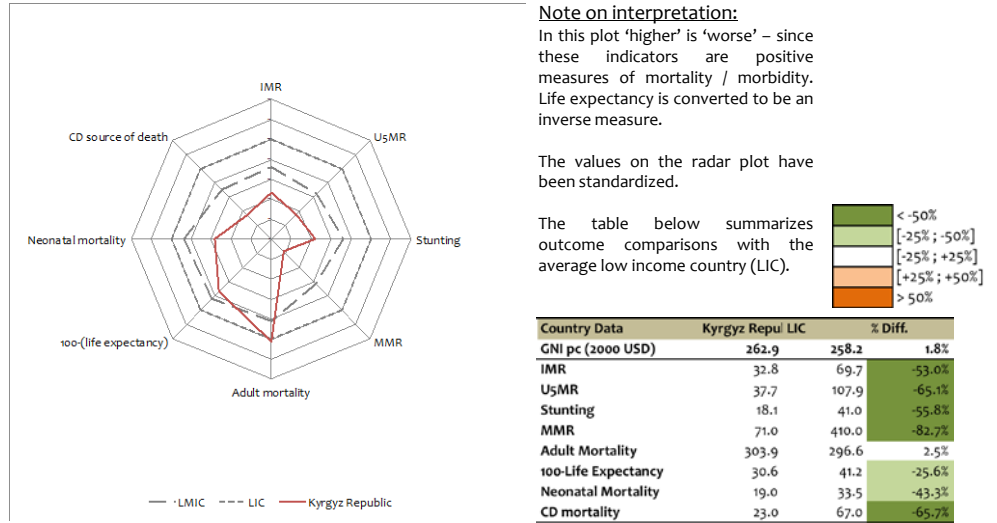
In this way, public resources channeled through the MHIF would continue to be targeted toward high-value health services comprising the SGBP. Supplementary Voluntary Health Insurance, however, would cover less essential aspects of health care and represent an alternative to the



widespread use of informal payments in the health sector. At the same time, encouraging individuals to opt out of the public system might not be such a good idea, since there is a risk that the majority of low-risk, wealthy, and quality-conscious patients would leave the public sector. It is likely to lead to a two-tier system—a poorly performing public, and a well performing private, one.

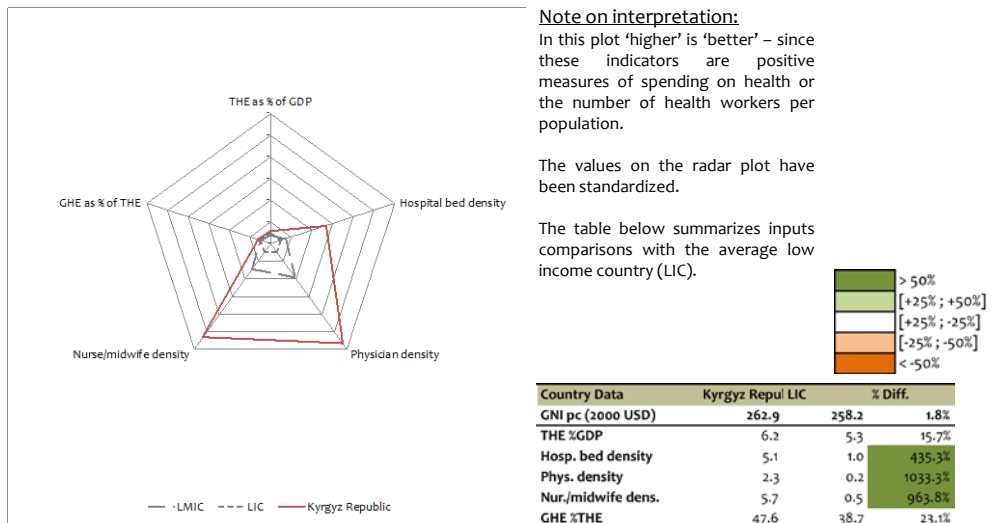
## Annex 1 Kyrgyz Republic and Low-income Countries

### I. Outcomes comparisons: Kyrgyz Republic and Low Income Countries



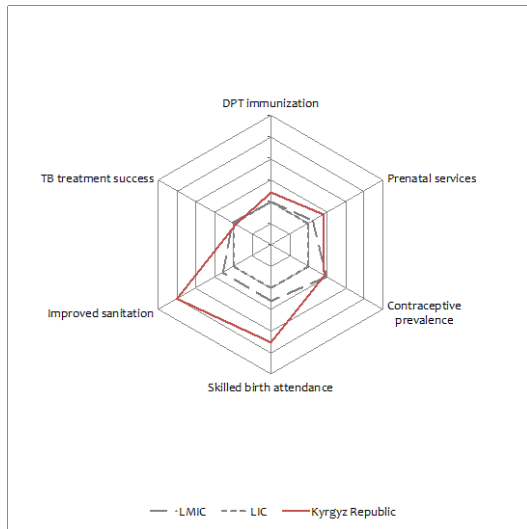
IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

### II. Inputs comparisons Kyrgyz Republic and Low Income Countries



THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

### III. Coverage comparisons Kyrgyz Republic and Low Income Countries

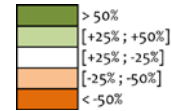


**Note on interpretation:**

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized.

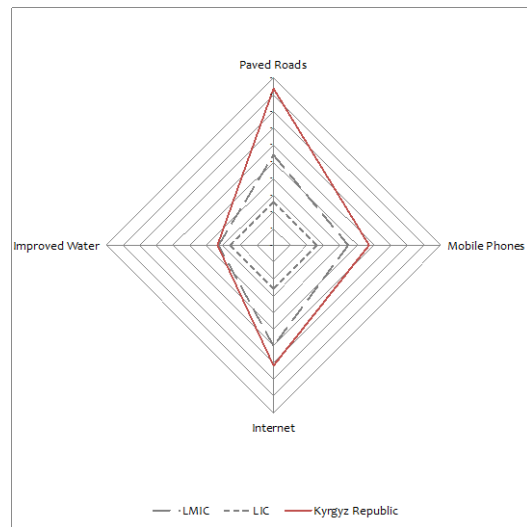
The table below summarizes coverage comparisons with the average low income country (LIC).



Country Data	Kyrgyz Repu	LIC	% Diff.
GNI pc (2000 USD)	262.9	258.2	1.8%
DPT	96.0	79.5	20.7%
Prenatal	96.9	68.9	40.6%
Contraceptive	47.8	33.6	42.3%
Skilled birth	98.5	43.6	126.0%
Sanitation	93.0	37.0	151.4%
TB success	82.0	86.0	-4.7%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

### IV. Infrastructure comparisons Kyrgyz Republic and Low Income Countries

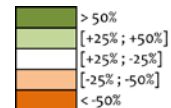


**Note on interpretation:**

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized.

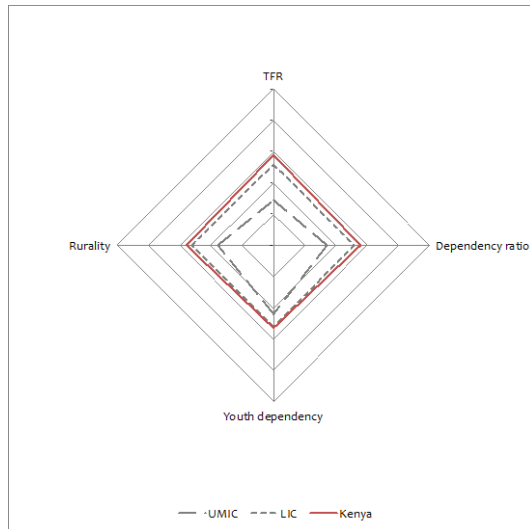
The table below summarizes infrastructure comparisons with the average low income country (LIC).



Country Data	Kyrgyz Repu	LIC	% Diff.
GNI pc (2000 USD)	262.9	258.2	1.8%
Paved roads	91.1	20.7	339.8%
Mobile phones	104.8	40.8	157.1%
Internet	19.6	5.9	230.0%
Water	90.0	65.1	38.1%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

## V. Demography comparisons Kyrgyz Republic and Low Income Countries

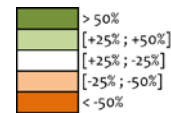


### Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized.

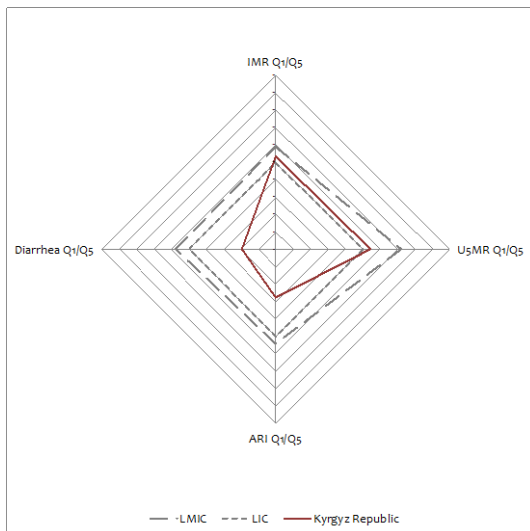
The table below summarizes demographic indicators comparisons with the average low income country (LIC).



Country Data	Kyrgyz Repu	LIC	% Diff.
GNI pc (2000 USD)	262.9	258.2	1.8%
TFR	2.9	4.1	-28.9%
Dependency (Total)	52.7	75.1	-29.9%
Youth share	87.1	91.5	-4.9%
Rural pop.	63.4	71.7	-11.6%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

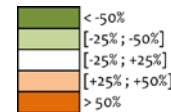
## VI. Inequality comparisons Kyrgyz Republic and Low Income Countries



### Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The table below summarizes inequality indicators comparisons with the average low income country (LIC).



Country Data	Kyrgyz Repu	LIC	% Diff.
GNI pc (2000 USD)	262.9	258.2	1.8%
IMR Q1/Q5	1.8	1.7	7.0%
U5MR Q1/Q5	2.0	1.8	8.6%
Stunting Q1/Q5	NA	1.9	
ARI Q1/Q5	0.7	1.2	-44.0%
Diarrhea Q1/Q5	0.5	1.3	-60.8%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

## **Annex 2 Brief Description of Public Health, Primary Care, and Key Supply-side Efforts**

Family group practices (FGPs) and Feldsher-Obstetrical Ambulatory Points (FAPs) are the first point of contact and act as gatekeepers to more specialized services in the Kyrgyz Republic. According to Decree #350 on SGBP (approved by the Government of the Kyrgyz Republic in 2011), basic primary health care services are provided free of charge for patients enrolled with a primary care provider, regardless of their insurance status. These services include general consultations, immunizations, and basic laboratory tests based on referral.

If patients need more specialized care, they are referred to specialists in Family Medicine Centers, Outpatient Units of hospitals, or General Practice Centers. Specialized services at the outpatient level are free for the groups exempted on the basis of social (such as World War II veterans) or disease (TB patients) categories. Those who are insured, welfare recipients, children between 5 and 16 years of age, the retired and labor veterans have a 50 percent copayment. All others must pay the full price according to the official price list developed by the Ministry of Health and agreed with the State Agency for Antimonopoly Policy and Development of Competition (Decree #350 on SGBP, 2011).

At the start of health care reform, the Kyrgyz health system was dominated by hospitals and a poorly developed level of primary health care (PHC), where 10.3 percent of the total health care budget was allocated to PHC compared with 71.7 percent allocated to hospitals (Atun 2005, 1). The restructuring of PHC began in 1995 in one region with the establishment of FGPs. In addition, FMCs were created in urban areas to retain the narrow specialists at the PHC level. In remote rural areas, FAPs were established to serve populations of between 500 and 2,000. The restructuring was accompanied by intense training of health workers in family medicine and increased allocation of total government health expenditures to primary care. By 2009, the share of total health expenditures on primary care had increased to 37.7 percent (Ibraimova et al. 2011). All of these processes led to the strengthening of primary care services. As pointed out in the evaluation of the “Manas” Program, “there is strong evidence from the analysis of the MHIF data demonstrating a shift from secondary to primary level with a decline in the number of hospital referrals for key acute and chronic conditions that are typically managed in PHC setting” (Atun 2005, 40).

According to the same study (Atun 2005), with the exception of a few extremely mountainous areas, there is good physical accessibility to PHC facilities, most of which are located close to patients’ homes, with a median distance of 1 to 2 kilometers. For most patients (73 percent), the travel time to the nearest health facility is less than half an hour (Atun 2005). However, there has been a growing shortage of health workers in rural areas, which has had a negative impact on access to and quality of PHC services (Manjjeva, Kojokeev, and Murzalieva 2008).

According to the Mid-Term Review of the “Manas Taalimi” Program, while at the PHC level the norm is one FGP per 1,500 people, the share of FGPs with more than 2,000 enrolled people is increasing in rural areas. In 2006, at the start of “Manas Taalimi,” 58 percent of rural FGPs had an enrolled population greater than 2,000, and the target was to reduce this to 33 percent. However, the indicator has actually been increasing, reaching 81 percent in 2007 (MOH 2008). In many rural areas, inability of the MOH to attract young graduates is leading to long-standing

vacancies, an increased workload for existing staff, and aging of the health worker population (Kojokeev, Murzalieva, and Manjjeva 2008; Manjjeva, Kojokeev, and Murzalieva 2008).

To attract and retain health workers in rural areas, the MOH has implemented the following measures:

- According to Article No. 97 of the 2005 Health Protection Law, students who received state scholarships for medical studies must serve in assigned rural areas for a minimum of two years following graduation.
- Originally developed to attract young doctors to rural areas with particularly high shortages of health staff, the Deposit Program for Doctors was gradually turned into a program to retain existing staff, without particular regard for their age (Manjjeva, Kojokeev, and Murzalieva 2008). It is a three-year program in which doctors willing to relocate to remote villages with acute shortage of medical personnel would receive 3,000 soms (US\$83) per month into their bank account (subject to income tax), which can be withdrawn only every six months (Manjjeva, Kojokeev, and Murzalieva 2008). Given the failure to recruit new doctors, the MOH decided to allow doctors to apply for their current positions so as to retain, at least, those physicians already working in these villages. The program has thus become a tool for retaining existing health workers more than attracting new ones. As of early 2009, there were 147 participants in the program. Of those, 20 were graduates of clinical residency and postgraduate study, and the remaining 127 were local doctors. By early 2010, the total amount paid to doctors working in this program was 6.3 million Kyrgyz soms.
- A one-year internship program was reestablished in 2007 requiring students to undertake practical training in the country's oblasts (oblast merged hospitals, oblast FMCs, territorial hospitals, and rayon FMCs), which are in mostly semi-urban and rural areas.
- Another measure to attract and retain health workers in rural areas is a gross salary bonus of 10 percent. The effectiveness of this measure has not yet been evaluated.

Since 2006, public health functions in the country have been shared between the Public Health Unit of the MOH, which has primary responsibility for public health policy making, and the Department of State Sanitary-Epidemiological Surveillance (SSES), which is responsible for infectious disease surveillance and sanitary inspection and control (Ibraimova et al. 2011). The SSES is subdivided into the Divisions of State Epidemiological Surveillance, State Sanitary Inspection and Control, and Laboratory Examinations.

In addition, the SSES services contain several legally independent bodies such as the Republican AIDS Association, the Republican Centre for Immunoprophylaxis, the Republican Centre for Quarantine and Dangerous Infections, the Republican Centre for Health Promotion, and the Research Institute for Preventive Medicine (Ibraimova, Akkazieva, and Ibraimov 2011). In the past, there was limited involvement of communities in health promotion activities. Nowadays, the Republican Center for Health Promotion develops and implements wide-ranging health promotion and population-based interventions. Village Health Committees have been established nationwide, and the national rollout of the Community Action for Health model was completed in 2008 (MOH 2008).

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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