

# TOWARD A MORE PRO-POOR AND EXPLICIT HEALTH BENEFIT PACKAGE IN THE KYRGYZ REPUBLIC:

*A Critical Review of the State Guaranteed Benefit Package and Options for its Revision*

DISCUSSION PAPER

July 2019

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## Health, Nutrition, and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## Toward a More Pro-Poor and Explicit Health Benefit Package in the Kyrgyz Republic: *A Critical Review of the State Guaranteed Benefit Package and Options for Its Revision*

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### **Abstract:**

The Kyrgyz Republic has made significant steps in reforming the health system through successive National Health Programs implemented over the last 20 years. One of the major achievements of such reforms was the establishment of a single-payer national health insurance and a basic benefit package. The State Guaranteed Benefit Package (SGBP) provides free basic health services at the primary care level for the whole population, and inpatient care with nominal copayments or no fee for certain groups.

Even though the principles of the SGBP contain elements of international good practice, the SGBP has hardly changed since it was established. At the same time, many changes have taken place within and outside the health system, exerting mounting pressure for the SGBP to adapt to the new disease burden and meet the population's expectations within the context of budget constraints.

The current paper provides a critical assessment of the Kyrgyz Republic's basic health benefit package. It reveals a number of issues in the actual benefits delivered to the population as opposed to the generous promise of the statutory package. Some important limitations include lack of clarity, persistent funding gap, the large number of fee exemption categories given the resource constraints, and at the same time lack of an effective mechanism to protect the poor. Most importantly, there is no systematic arrangement in place to ensure a regular evidence-based process to revise the benefit package.

The paper proposes several measures that could guide the process of SGBP revision, taking into account the particular Kyrgyz context and building on international experiences. It is expected that information from the paper will be useful not only for Kyrgyz stakeholders, but also for other countries in making the benefit package an effective instrument for achieving universal health coverage.

**Keywords:** State Guaranteed Benefit Package, Benefit Package Revision, Universal Health Coverage, Pro-poor, Kyrgyz Republic.

**Disclaimer:** The findings, interpretations, and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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## Table of Contents

ACKNOWLEDGMENTS.....	VI
ACRONYMS .....	VII
1. INTRODUCTION .....	1
2. APPROACHES IN DEFINING HEALTH BENEFIT PACKAGES .....	3
3. THE STATE GUARANTEED BENEFIT PACKAGE IN THE KYRGYZ REPUBLIC.....	5
4. A CRITICAL ASSESSMENT OF THE SGBP .....	14
5. TOWARD A MORE PRO-POOR AND EXPLICIT BENEFIT PACKAGE .....	23
<i>MAKING POVERTY-TARGETING CENTRAL IN THE SUBSIDIZATION OF THE SGBP .....</i>	<i>23</i>
<i>BUILDING ON THE EXISTING EXTENSIVE CLINICAL GUIDELINES AND CARE PATHWAYS TO DEVELOP A DETAILED LIST OF SERVICES INCLUDED IN THE SGBP.....</i>	<i>25</i>
<i>DEVELOPING AN APPROACH TO ONGOING REGULAR REVISIONS OF SGBP.....</i>	<i>29</i>
6. CONCLUSION .....	31
REFERENCES .....	32
ANNEXES .....	34
ANNEX 1. CATEGORIES OF POPULATION ELIGIBLE FOR COPAYMENT REDUCTION AND EXEMPTION .....	34
ANNEX 2: KEY PRINCIPLES FOR DEFINING AND REVISING THE HEALTH BENEFIT PACKAGE.....	36
ANNEX 3. EXAMPLES OF CAP ON OUT-OF-POCKET PAYMENT, OECD COUNTRIES.....	40

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## ACRONYMS

ADP	Additional Drugs Package
DOTS	Directly Observed Treatment, Short Course
DRG	Diagnosis related group
EMS	Emergency Medical Service
FMC	Family Medicine Center
HbA1C	Glycated Hemoglobin Test
HIV	Human Immunodeficiency Virus
HR	Human Resources
HTA	Health Technology Assessment
ICD-10	International Statistical Classification of Diseases and Related Health Problems, tenth revision
ICPC	International Classification of Primary Care
KIHS	Kyrgyz Integrated Household Survey
MHI	Mandatory Health Insurance
MHIF	Mandatory Health Insurance Fund
MISSOC	Mutual Information System on Social Protection
MoF	Ministry of Finance
MoH	Ministry of Health
MoLSD	Ministry of Labor and Social Development
MR	Magnetic Resonance
NCD	Non-communicable disease
OOP	Out-of-pocket expenditure
OP	Outpatient Care
PHC	Primary Health Care
PHRD	Grant supported by the Japan Policy and Human Resource Development Trust Fund
ReHC	Republican eHealth Center
SGBP	State Guaranteed Benefit Package
SWAp	Sector-Wide Approach Project
TA	Technical Assistance
ToR	Terms of Reference
UHC	Universal Health Coverage
WB	World Bank
WDI	World Development Indicator
WHO	World Health Organization

## 1. INTRODUCTION

The Kyrgyz Republic is regarded as a pioneer in health system reforms among its peers in Central Asia and the former Soviet Union (Ibraimova et al. 2011). The country has adopted successive health reforms since the early 1990s and has introduced significant changes in financing and service delivery arrangements. Some of the most prominent features of the early reforms include an establishment of a single purchaser of services, the Mandatory Health Insurance Fund (MHIF), and a basic benefit package for the whole population. As such, the country aspired to the principles of universal health coverage (UHC) more than 20 years ago.

The benefit package defining health entitlements was adopted to ensure that essential health services are guaranteed to the whole population. Famously known in the country as the State Guaranteed Benefit Package (SGBP), it offers free basic health services at the primary care level for the whole population and subsidized inpatient care for a large group of beneficiaries. The MHIF is financed mainly through general tax revenue and insurance premiums. It pays primary health care (PHC) providers through capitation and pays hospitals based on a simple form of diagnosis related groups (DRGs). Currently, funding for the SGBP accounts for nearly 80 percent of total government current health spending.

Despite early successes in health system reforms and efforts to make basic services available to the whole population, the Kyrgyz Republic is still struggling to attain effective UHC. Its population is faced with a double disease burden—a growing incidence of noncommunicable diseases (NCDs) as well as the persistent prevalence of some important communicable diseases and maternal and child health conditions. This situation imposes considerable financial pressure on the health system. Some other challenges are related to the inefficiency in resource use and ineffective financial protection for the poor. To ensure effective coverage of the SGBP, there is a need to refine its content and scope so that the benefits are aligned with the country's health needs and available financial resources.

Several studies have directly or indirectly addressed the issue of the SGBP in the Kyrgyz Republic (Giuffrida, Jacob, and Dale 2013; Manjjeva et al. 2007). They highlighted a persistent funding gap, which then further increased out-of-pocket (OOP) expenditures, including informal payments. Previous studies also pointed to a large and increasing number of patients entitled to fee exemptions in the public hospitals, which imposed a major burden on the already constrained resource envelop of the SGBP. None of the studies dived deeply into the granularity of the SGBP to analyze its structure and offer recommendations on how to overcome its constraints.

The current paper provides a critical review of the health benefit package in the Kyrgyz Republic and offers several options for its revision. It represents a significant addition to the existing literature in several ways. First, it highlights the key bottlenecks limiting the

SGBP's ability to serve as an instrument for achieving effective UHC. It then offers practical recommendations to guide the revisions of the SGBP. The primary audience for this paper are key health sector stakeholders in the Kyrgyz Republic, in particular the Ministry of Health (MoH), Mandatory Health Insurance Fund (MHIF), Ministry of Finance (MoF), and Ministry of Labor and Social Development (MoLSD). As the country determines to take systematic steps in revising the SGBP in the coming years, this paper will provide a useful framework to guide such efforts. In addition, by sharing the Kyrgyz experience, the paper contributes to the international literature, which so far mainly touches upon broad-level principles of health benefit packages. As more and more countries are struggling to balance ambitions and constraints in defining and revising their health benefit package, the lessons from the Kyrgyz Republic will be useful for them in developing their own practical solutions.

The paper's Section 2 sets the stage with a brief review of common approaches in defining health benefit packages. Section 3 starts with a description of the "statutory benefit package" in the Kyrgyz Republic—the SGBP as it is specified in the legal documents—and Section 4 presents a critical assessment of its actual performance. As a preview, challenges facing the "de facto" SGBP do not rest only in the funding shortage, although this certainly is a major issue. The de facto SGBP also falls short in its lack of clarity and transparency, and given the overwhelming size of the population entitled to free services, it has limited ability to fulfil such a promise, no effective poverty-targeting mechanism, a weak information base for monitoring and management, and most importantly, the lack of a systematic methodology and mechanism for its revision. Recommendations to address some of the challenges are provided in Section 5, and finally, Section 6 offers some concluding observations.

## 2. APPROACHES IN DEFINING HEALTH BENEFIT PACKAGES

Health benefit packages can be described in various ways: by level of care (primary, secondary, or tertiary care); by health conditions (maternal and child health, family planning, cardiovascular, etc.); or by a specific list of services covered (or not covered) (Cotlear et al. 2015). The last example demonstrates an “explicit” benefit package, which is described in a positive (and/or negative) list, as opposed to an “implicit” definition, which refers to broad categories of services.

In principle, as defined, the implicit and explicit benefit package each has pros and cons. The implicit definition gives more flexibility to health care providers and patients. Adopting new technologies may be easier without the constraints of regulatory delays. Implicit rationing can coexist with proactive strategies for priority setting, review of evidence, and evaluation of health care services’ cost- effectiveness, as in the case of the United Kingdom. The explicit definition, on the other hand, allows for a better allocation of resources to cost-effective health care interventions. However, countries following this route may risk delaying the adoption of new and useful technologies.

According to Glassman, Giedion, and Smith (2017), an explicit benefit package is preferred for a number of reasons. Most importantly (i) by creating explicit entitlements for the population, it empowers poor and marginalized groups, who otherwise would not be aware of any specific entitlement; (ii) it increases transparency and helps reduce informal payments; (iii) it allows for proper costing of services committed to the population, and facilitates planning of service delivery and resource allocation; and (iv) it helps to decide whether funds are being spent wisely and on services that create maximum benefits for the society.

With the heightened global attention to UHC, a general movement toward explicit benefit packages has been observed in many countries. Specifically, among twenty-four UHC programs recently reviewed by the World Bank, all but three adopted an explicit benefit package and used complex mechanisms in setting priorities for these packages (Cotlear et al. 2015). For example, in Thailand, the benefit package is defined by positive and negative lists, consisting of health conditions, clinical procedures, and other detailed categories. In Estonia, the benefit package is defined by the “List of Health Services” (based on government decisions). It has an explicitly defined benefit package structured as an inclusion list. In Mexico, the Seguro Popular administers two explicit health care packages: a set of mainstream primary care and general hospitalization services that includes 284 interventions and a set of high-cost/high-complexity services that includes 61 interventions. The two explicit benefit packages were deemed effective tools for achieving UHC in the country (González-Pier 2017). Across countries in Latin America and the Caribbean, there has been a pattern of adopting explicit benefit plans to cover the entire population or target groups (Giedion et al. 2013).

Other noteworthy patterns emerged from the World Bank’s review of 24 programs that pertain to the practical implementation and target issues of the benefit package. For example, it was revealed that de facto benefit packages in most countries are smaller than what is promised (Cotlear et al. 2015), which signals the need to look beyond statutory benefits to see how much is actually delivered to the population.

The benefit package discussions go far beyond “what’s in, what’s out.” Intrinsically related to the package of services are issues such as cost-sharing processes, how benefits are administered, incentives, care delivery options, and complaint review processes, among others. As an example, some key features of a health benefit package recommended by the nonprofit Institute of Medicine to health plans participating in “Obama Care” in the United States are listed below (Box 1).

### **Box 1. Benefit Package Design**

The benefit package includes the following:

1. Description of covered benefits: services, drugs, devices
2. Description of the cost-sharing process
3. List of coverage exclusions
4. Identification of provider networks, incentives, and care delivery options
5. Medical management and/or utilization management programs (e.g., when prior authorization is required for specific services, site of service, level of care, or preferred providers)
6. Payment policies that affect coverage or cost-sharing
7. Overall description of how benefits are administered, including description of the complaint, request for review, and appeals processes

*Source:* Reproduced, with simplification, from the Institute of Medicine (2012).

Box 1 provides a useful framework for comprehensively approaching the issues of the benefit package. However, its full application could be constrained in less developed health systems. Countries are usually faced with technical and political challenges—in data availability and quality, analytical capacity, and the ability to balance among various interests. Some of the more relevant issues for the Kyrgyz Republic will be reviewed in detail in the later sections of this paper.

### **3. THE STATE GUARANTEED BENEFIT PACKAGE IN THE KYRGYZ REPUBLIC**

#### **Regulatory Framework and Institutional Arrangement for the SGBP**

The SGBP is administered through a program of state guarantees to ensure volumes, types, and conditions in the provision of medical care to ensure people's rights to health care in accordance with Kyrgyz legislation. According to the Health Care Law, the MoH is responsible for the development of the SGBP, while the MHIF is responsible for its administration. However, decision making regarding the SGBP extends well beyond health sector stakeholders.

Responsibilities of different stakeholders related to the SGBP are described below:

- MoH is responsible for defining and revising the SGBP, often in collaboration with the MHIF.
- MHIF takes part in the development of SGBP and acts as a single purchaser of the SGBP. In case of financial shortfalls, MHIF can initiate proposals on the revision of SGBP.
- MoLSD is tasked with developing policies and administering various social support programs that have direct implications on SGBP's beneficiary population. Specifically, it administers the categories of the population that are eligible for free or subsidized services based on their social status ("social categories"). At present, there are 30 such categories. The MoLSD is also in charge of identifying and certifying the poor, some of them are included among the 30 social categories of the SGBP.
- Government approves the SGBP proposed by the MoH.
- MoF examines and approves state budget proposals for health, with SGBP comprising nearly 80 percent of the total.
- Parliament approves financial parameters for the respective year for the SGBP.

Before 2015, the Health Care Law required a revision to the SGBP every year. The law, however, did not set out a process for SGBP revision, and there was no existing protocol or guideline on how the revision could be done. Often, the SGBP revision process meant that the minister of health would issue an order to establish a working group tasked with developing a draft of the revised SGBP. The working group typically consisted of representatives from the MoH, MHIF, MoLSD, and MoF. After the working group developed a draft SGBP, it would submit the draft to the minister of health. Subsequently, the draft would be circulated among all ministries for concurrence before going to the Prime Minister's Office. The final version of the SGBP was approved by the prime minister through a resolution.

As seen, the process of revising the SGBP involved many steps and multiple stakeholders, which typically leads to a delay in the approval of the package. For example, in 2015 the

SGBP was not approved until November. Due to the challenges in the annual revision of the SGBP, after 2015, it was decided that the SGBP would only be revised “when needed,” and there has been no major revision since then.

### **The Statutory Benefit Package**

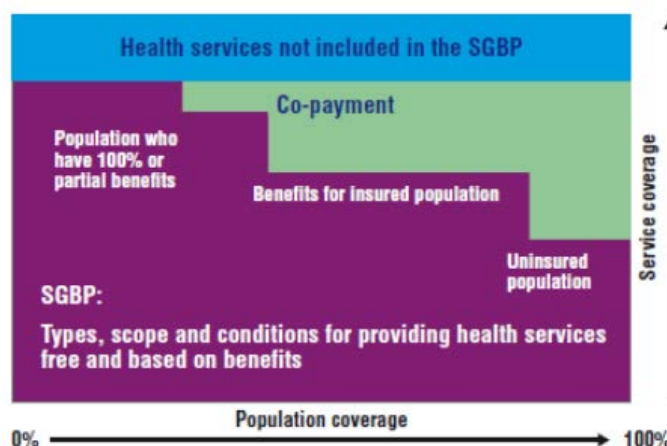
The latest version of the SGBP was approved by the government of the Kyrgyz Republic on November 20, 2015 (Order № 790) and slightly amended several times since then. With some exceptions, the SGBP is largely an implicit package—it defines general conditions for health care provision for each level and type of care, a list of laboratory tests, and categories of citizens entitled to copayment reduction and exemption. In addition, limited outpatient drug benefits are available to people with certain diseases and to the insured. From 2016, MHIF also started administering some costly specialized services (oncology, hematology, cardiac surgery, and psychiatry).

As stipulated by the law, the state-guaranteed program provides the following types of medical services:

- Primary health care
- Emergency medical care at the outpatient level
- Emergency medical consultative care (air medical services)
- Specialized medical care at the outpatient level
- Inpatient care
- Medical aid provided by the MHIF for the high-tech (expensive) types of medical care
- Dental care
- Drug and vaccine supply
- Immunoprophylaxis

Figure 1 below provides a pictorial representation of the SGBP. As shown, basic services, which include health promotion and prevention, and some basic lab tests at the PHC level are made available for free to 100 percent of the population, regardless of insurance status. For people with social health insurance, coverage is higher, and copayment for non-free services is lower. Certain population groups enjoy 100 percent or partial benefits (the so-called “population who have 100 percent or partial benefits” in the diagram). Currently, there are 30 groups for whom benefits are granted based on their social status, and 16 groups for whom benefits are granted based on their underlying medical conditions. The architecture of the SGBP remains unchanged since its inception.

Figure 1. A Pictorial Presentation of the SGBP



Source: Reproduced from Kutzin et al. 2002.

Funding for purchasing the SGBP is exclusively managed by the MHIF, which absorbs 80 percent of the central government spending on health, not including capital construction. Table 1 below shows the MHIF's amount and relative share toward purchasing the SGBP at the primary care and hospital levels (shaded box). As shown, 97 percent of MHIF's funding (all but expenditure for administration and hemodialysis) goes to the SGBP (32.5 percent for PHC and 64.5 percent for hospital services, respectively).

Table 1. MHIF's Funding for Purchasing the SGBP, 2018

Funding for purchasing the SGBP by level of care	'000 Kyrgyz soms	%
SGBP at PHC level	4,619,023	32.5
<i>PHC services</i>	3,852,337	27.1
<i>Ambulance services</i>	447,250	3.1
<i>Drug benefits under state program</i>	55,000	0.4
<i>Additional drugs package</i>	264,435	1.9
SGBP at hospital level	9,181,303	64.5
<i>General inpatient services</i>	8,644,698	60.7
<i>Specialized services (oncology, psychology, hematology, cardiac surgery)</i>	536,605	3.8
Hemodialysis	286,000	2.0
Administration	144,000	1.0
<b>Total</b>	<b>14,230,326</b>	<b>100.0</b>

Source: Data from MHIF (2018a).

Note: Exchange rate US\$1 = 70 Kyrgyz soms.



Details of the SGBP are provided below.

**(i) Primary health care**

Prevention (protection and promotion of health and healthy lifestyle; immunization; anti-epidemic activities; training in self-control, self-help, and mutual assistance); diagnostic procedures (basic laboratory and diagnostic tests); and therapy (emergency medical assistance, prescription of medical treatment, medical injections, rehabilitation and physiotherapy) are provided at the PHC level.

The following basic laboratory tests in PHC are included in SGBP:

- Complete blood count
- Urinalysis and microscopic sediment examination
- Urethral smear microscopic examination
- Vaginal swab microscopic examination
- Sputum microscopic examination
- Blood glucose
- Urinary glucose
- Blood cholesterol

**(ii) Inpatient care**

Inpatient care is free of charge for all citizens admitted to the hospitals for emergency medical care until elimination of life-threatening conditions and upon stabilization of hemodynamic and respiratory functions. Subsequently, patients are treated according to the terms of planned inpatient care. Payment for inpatient services depends on the patient's status. Services provided by hospitals under the SGBP are not specified.

**(iii) Dental care**

Dental examinations and cleaning are provided for free to children up to 10 years old, pensioners aged 70 and older, and women registered as pregnant at the place of their residence. All citizens are entitled to free dental examinations and emergency dental care, including required medications.

**(iv) Outpatient drug benefits**

Outpatient drug benefits are provided in two different programs: (i) drug supply to insured citizens under the Additional Drugs Package (ADP); and (ii) drug supply to certain categories of patients (patients with bronchial asthma, epilepsy, paranoid schizophrenia, affective disorders, and cancer) under the Program of the State Guarantees. Currently, the two program documents are combined into one regulation, approved by a Decree of the Government of the Kyrgyz Republic on January 12, 2012.

The list of drugs that can be prescribed and sold within the two programs is included in the special "Directory of Drugs Reimbursed under the Additional Mandatory Health Insurance Program and the Program of the State Guarantees," which is available in every doctor's office and pharmacy. The Directory of Drugs contains more than 200 names of

medicines and the reimbursement amount in Kyrgyz soms per one unit of dosage (a pill, a coated pill, an ampoule for injection, an extended-release pill, and a dose of aerosol, etc.).

**Table 2. Beneficiary Groups for Outpatient Drugs under the Additional Drugs Package and the Program of State Guarantees**

ADP program	Program of state guarantees
<ul style="list-style-type: none"> <li>▪ Workers for whom the employer makes contributions to the Social Insurance Fund</li> <li>▪ Pensioners</li> <li>▪ Persons receiving social benefits</li> <li>▪ Children under 16</li> <li>▪ Farmers and their family members who pay insurance contributions to the Social Insurance Fund</li> <li>▪ Persons with Medical Health Insurance policy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patients with epilepsy</li> <li>▪ Patients with bronchial asthma</li> <li>▪ Patients with paranoid schizophrenia</li> <li>▪ Patients with affective disorders</li> <li>▪ Patients with cancer assigned to family group practice and subject to regular medical checkups</li> </ul>

Source: MHIF (2018b)

Under the outpatient drug benefit programs, the MHIF has an agreement with participating pharmacies so that patients only pay part of the cost of the purchased drugs (with prescriptions), and a part of the cost is paid directly to the pharmacies by the MHIF. The list of pharmacies operating under the two drug benefit programs (with their addresses) is posted on the information board in each family medicine center and on MHIF’s website. Under the ADP, the MHIF sets a rate to reimburse participating pharmacies at 50 percent of the median wholesale price. Patients pay the difference between the retail price of the drugs and the amount MHIF reimburses the pharmacies. A normative of som 70 (US\$1) per person is set by MHIF as the basis for the annual budgeting of the ADP.

Under the Program of State Guarantees, outpatient drug benefits include a list of free drugs and a list of subsidized drugs. Patients with insulin-dependent diabetes mellitus, non-insulin-dependent diabetes mellitus, diabetes insipidus, hemophilia, and tuberculosis are entitled to free prescriptions. Patients with epilepsy, bronchial asthma, and terminal cancer are entitled to subsidized prescriptions. Both the list of conditions and volume of drugs allowed for each condition is very limited. For example, the table below shows the list of conditions that are entitled to free prescriptions.

**Table 3. Diseases Entitled to Free Prescriptions and Respective Volume Caps**

Disease	Drug or medical device	Rate of distribution per patient per year
Insulin-dependent diabetes	Insulin, syringes	As needed
Non-insulin dependent diabetes	Glibenclamide 5 mg	5 packages (600 pills)
Diabetes insipidus	Desmopressin 5 ml	20 vials
Hemophilia	Cryoprecipitate 15 mg	20 vials
Tuberculosis	Under DOTS Program	As needed
Children under 16 with hemophilia	Concentrates of factors VIII/IX	6,500 ME

Source: Government of the Kyrgyz Republic 2015.

Note: DOTS = Directly Observed Treatment, Short-Course.

### (v) Copayment

Most primary care and outpatient specialist services are free. Some have copayments, depending on the patient's status. For inpatient care, there is a simple copayment scheme, defined at three levels (minimum, average, and maximum), for therapeutic and surgical profiles and for tertiary versus other types of hospitals.

**Table 4: Copayment Rates per Hospitalization (Kyrgyz soms)**

Forms of copayment		All hospitals excepts tertiary	Tertiary hospitals
Copayment of the therapeutic profile	Minimum	330	330
	Average	840	1,160
	Maximum	2,650	2,980
Copayment of the surgical profile	Minimum	430	430
	Average	1,090	1,510
	Maximum	3,440	3,870

Source: Government of the Kyrgyz Republic 2015.

Note: Exchange rate: US\$1 = 70 Kyrgyz soms.

A patient's copayment level depends on his or her insurance status and whether he or she belongs to one of the groups eligible for reduction or exemption. Citizens entitled to SGBP copayment reduction or exemption are divided into two categories:

- Exemption or reduction based on social status (30 categories)
- Exemption or reduction based on clinical indications of the underlying disease (16 categories)

The list of social and medical categories is provided in Annex 1. As can be seen, the list is extensive. Many of the social categories include people of merits (i.e., those who have served the country), while others can be considered disadvantaged (i.e., people with disabilities). However, it is not clear if all categories are in financial need of full subsidization. The same observation is applied to the 16 medical groups. As reported by the MHIF, the benefits of most of the 30+16 categories are dictated by different laws, and

changes to their benefits would involve amendment not only in the SGBP regulations but in other relevant laws as well.

The list of eligible categories is occasionally revised, typically to add rather than to remove benefits. For example, the Resolution of the Government of the Kyrgyz Republic of September 7, 2018, No. 420, "On amendments to certain resolutions of the government of the Kyrgyz Republic in the field of health care and health insurance" extended the categories entitled to free medical care at the outpatient level to include the following categories of insured people: (i) unemployed population officially registered in the public employment service, (ii) students of secondary and higher educational institutions of full-time education until the age of 21, and (iii) military personnel.

There is a cap to inpatient benefits for most patients. For example, except for children under six, all social categories have a cap of two free admissions per year, and the third or further admissions are subject to average copayment. Furthermore, there is no stop-loss provision in the SGBP.<sup>1</sup> To the contrary, the legislation stipulates that when the actual cost of providing medication to a patient is three times higher than the average cost of the treatment, as approved by the authorized state body in the field of mandatory health insurance, the Treatment and Control Committee of the hospital may decide to charge the patient extra for drugs required for further treatment, regardless of the patient's entitlement to benefits.

#### **(vi) Specialized services**

In 2016, four specialized services of oncology, hematology, cardiac surgery, and psychiatry (mental health) were integrated into the SGBP (O'Dougherty and Akkazieva 2016). Previously, they were either vertical systems or specialized services funded directly by the MoH. As for other services included in SGBP, specialized services/procedures are not explicitly defined. Only the categories of citizens entitled to these services and levels of copayment are described in detail.

For example, inpatient oncological care is free for children under 16 years, participants and disabled veterans of the Great Patriotic War, military staff, invalids of the Soviet Army, invalids among the soldiers-internationalists, persons affected by the Chernobyl disaster, and children (up to 18 years) of persons affected by the Chernobyl disaster. Oncological care is provided, as follows:

- Minimum level copayment for pensioners and veterans of labor older than 70 years, persons with disabilities from childhood, persons receiving state benefits

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1, A stop-loss provision is a specific clause in a health insurance policy with a deductible and co-insurance arrangement that states that insured persons need no longer pay any percentage of the medical expenses once their out-of-pocket expenses have reached the specific amount or limit indicated in the policy (<https://www.insuranceopedia.com/definition/4373/stop-loss-provision>).

- Average level of copayment for citizens insured by the MHIF, persons employed in agriculture who are paying contributions for compulsory health insurance, contracted military service persons insured by the MHIF
- Maximum level of copayment for other categories of citizens

Chemotherapy is provided to all citizens with additional copayment based on the cost of services according to the MHIF price list.

Restrictions are expressed in a negative list. Citizens, regardless of their entitlement to benefits, shall pay according to the price list, for the following high-cost examinations and manipulations:

- Angiography of peripheral vessels, brain vessel, and internal organs
- Angiocardiology for heart valvular defects
- Hemosorption
- Hemodialysis
- Computer tomography
- Coronarography
- Plasmapheresis
- MR-imaging
- Lithotripsy

These procedures are free of charge for disabled veterans and veterans of the Great Patriotic War when they are referred by the appropriate specialist.

Based on the description above, it is clear that a closer look at the SGBP reveals it to be more complicated than its pictorial representation in Figure 1 suggests. Table 5 attempts to combine the main contents of the SGBP by level of care and population groups.

**Table 5. Main Content of the SGBP by Level of Care, Population Groups, and Fee (Copayment) Level**

Services/Patient category		30 social conditions	16 medical conditions	Insured	Rest of the population
Primary Health Care	<i>Prevention, basic lab,* therapy</i>	Free	Free	Free	Free
	<i>Other labs</i>	Free	Free	Free	Full price
	<i>Rehab, physiotherapy</i>	Full price	Full price	Free	Full price
Outpatient care (OP) except specialized services	<i>secondary care OP setting</i>	Free	Free	Full price	Full price
	<i>Advisory &amp; diagnostic department hospital</i>	Free	Free	Full price	Full price

<i>Inpatient care (IP) except specialized services</i>		Free for 2 IPs/year, average copay from 3rd (except U5 and some categories)	Free, no limit	Average copay	Max copay
<i>Outpatient drugs</i>	<i>General</i>	Discount for some beneficiaries' categories	Discount if among specified diseases	Discount	Full price
	<i>Specific diseases</i>	Free or discount depending on diseases			
<i>Inpatient drugs</i>		Free up to 3 times average cost			
<i>Specialized psychiatric care</i>	<i>Outpatient</i>	Free	Free	Free	Free
	<i>Inpatient</i>	Free	Free	Free	Free
<i>Oncological care</i>	<i>Outpatient</i>	Free for some beneficiaries categories	Free for some beneficiaries categories	Free	Full price
	<i>Inpatient</i>	Free for some beneficiaries categories, some categories have max copay	Free for some beneficiaries categories, some categories have max copay	Average copay	Max copay
<i>Hematological care</i>	<i>Outpatient</i>	Free	Free	Free	Free
	<i>Inpatient</i>	Free for some beneficiaries categories, some categories have max copay	Free for some beneficiaries categories, some categories have max copay	Average copay	Max copay
<i>Cardiac surgery and organ transplant</i>	<i>Outpatient</i>	Free for some beneficiaries categories, some categories pay full price	Free for some beneficiaries categories, some categories pay full price	Full price	Full price
	<i>Inpatient</i>	Free for some beneficiaries categories, some categories have copay based on the specific formula	Copay based on the specific formula	Copay based on the specific formula	Copay based on the specific formula

Source: Authors, based on the SGBP description, Government of the Kyrgyz Republic 2015.

Note: U5 =Under-five.

## 4. A CRITICAL ASSESSMENT OF THE SGBP

As revealed in the description of the statutory package, the basic idea of the SGBP can be considered rather progressive. Given its resource constraints, the country chose to make basic services available for free to the whole population, while giving further benefits to selected groups. Other features of the system, established some 20 years ago, remain good practices by international standards until today. Among others, these features include national pooling of fund and standardized service packages across regions managed by a single purchaser, which are necessary conditions for geographical equity, efficiency, and quality.

At the same time, looking beyond the statutory package, a critical review of the actual manifestation of the SGBP reveals a number of issues. Some of these are elaborated below.

### Complicated and confusing

The SGBP as described in various legal documents is complicated and confusing to lay people. As shown in table 5 above, even within primary care, some services are free to the whole population, while others require payment from certain groups. For inpatient care, some groups have unlimited benefits, while others are subject to a cap. Within the ADP, MHIF only covers 50 percent of the price that it has agreed with pharmacies, and pharmacies are free to set the retail price and collect the difference from patients. Therefore, patients themselves have to navigate among participating pharmacies to find the one with lower retail prices, if they know there is such an option.

The population's awareness of the SGBP can be ascertained from household surveys. Table 6 below presents the results from a nationally representative survey conducted with 4,665 households in 2014, the Kyrgyz Integrated Household Survey (KIHS).<sup>2</sup> The survey asked the head of household—presumably the most knowledgeable person of the household—if he or she knew whether certain services at PHC were free or not.

**Table 6. Population Knowledge about the SGBP at PHC**

*(Survey respondents' answers to the question: "If the following services at PHC are free or not?")*

Type of services	Free (%)	Not free (%)	DK (%)
Consultation with primary care practitioner	93.7	2.9	3.4
Consultation with specialist	60.3	27.2	12.5
Blood or urine test	51.6	43.4	5.0

<sup>2</sup> 2014 is the latest year for which an extended health module was added to the KIHS.

Hormone analysis, kidney test, test for rheumatism	12.9	65.1	22.0
Blood pressure measurement	87.5	5.9	6.6
Ambulance services (except private)	70.2	16.1	13.7
Ultrasound for pregnant women	33.1	42.5	24.4

Source: Data from KIHS 2014. DK: do not know

The first point to note from the table is that there was a large percentage of people giving a wrong answer. For example, the percentage of respondents who thought fees would be required for services that are in fact free by the SGBP regulation was 43.4 percent for basic blood and urine tests, 16.1 percent for ambulance service, and 42.5 percent for ultrasound for pregnant women. But this could be due to the fact that people do have to pay extra for free services (in a form of informal payment, for example) rather than to poor understanding of the SGBP. More remarkable is that an appreciable proportion of respondents actually did not know if common services at PHC were free (13.7 percent for ambulance services and 24.4 percent for ultrasound for pregnant women). Given that PHC should be the most frequent provider, the low awareness of the SGBP at PHC is concerning and this could partly explain why PHC has not been attractive to the population.

Similar patterns can be seen from table 7 below, which asks about payment for outpatient drugs and inpatient care. Between 11 and 23 percent of survey respondents reported not knowing if they were entitled to subsidized drug prices or if they would have to pay beyond the official copayment while hospitalized.

**Table 7: Population Knowledge about Outpatient Drug and Inpatients Benefits under the SGBP**

Questions	Yes	No	DK	NA
Are you entitled to receive outpatient drugs at subsidized prices?	46.0	42.2	11.8	
Are your children under 16 years of age entitled to receive outpatient drugs at reduced prices?	28.4	33.2	22.7	15.8
Imagine that you have been hospitalized. You have already paid an official copayment. Do you have to pay in addition to medical personnel?	14.1	74.8	11.1	
Imagine that you have been hospitalized. You have already paid an official copayment. Do you have to pay in addition for medicines during your hospitalization?	36.6	51.4	12.0	

Source: Data from KIHS 2014.

Note: DK (Do not know), NA (not applicable)

### **Not explicit and hence not transparent and guaranteed**

The statutory benefit package is largely defined by level of care. Even though there is a list of some basic lab tests at PHC, the package is best characterized as broad and implicit. Lack of a clear positive list of covered services makes it difficult for the patients to know what they are entitled to, as we have seen in the subsection above. The situation creates



a murky area concerning whether certain therapeutic services, procedures, tests, and supplies are subject to MHIF reimbursement.

For example, even though “women admitted for childbirth” are among the 16 categories of population entitled to fee exemption based on health condition, it is written nowhere that blood transfusion during delivery is included in the SGBP. Therefore, if a woman needs blood transfusion during delivery, most likely she would have to pay for it out of pocket. “Diabetics” is another example—the condition is listed among those eligible for free/subsidized services at outpatient and inpatient facilities, yet the Glycated Hemoglobin Test (HbA1C), which is a common and reliable test for monitoring blood sugar among diabetic patients, is not offered at the PHC. In rare cases where it is offered in a public facility, the patient is subject to the full cost of the test (World Bank 2019).

### **Limited coverage even for included services**

The SGBP is perceived by stakeholders in the country as having a “declaratory nature”—a promise that is not accompanied with adequate funding. Despite the ambition to cover all citizens with basic services and provide generous inpatient benefits for a large share of the population, public funding allocated to the SGBP was merely US\$30 per person in 2018. Funding allocated to providers does not cover the needs for drugs or the full cost of services. As seen in the description of the statutory package, for example, the list of drugs under free prescription categories is extremely limited. This necessitates implicit rationing by providers, in addition to all forms of extra collections for drugs, services, foods, and personnel (Jacab, Akkazieva, and Kutzin 2016).

For example, in 2017, spending on the ADP accounted for less than 1.8 percent of MHIF expenditure, and only 900,000 prescriptions were reimbursed. Given that there were about 4.5 million insured people, this translates to 0.2 prescriptions per person per year. The normative used by the MHIF is US\$1 per insured patient. Furthermore, without a mechanism to control price and regulate markup effectively, reimbursement from the MHIF is often less than 50 percent of retail price. Anecdotal evidence reveals that retail prices of some basic drugs in the Kyrgyz Republic are higher than in wealthier countries, yet imposing another layer of financial burden on the patients.

To illustrate the point, table 8 provides a rough comparison between the ADP’s actual spending and the estimated need for some common items—drugs for hypertension, diabetes mellitus, anemia, and contraceptives (injections and oral). For hypertension and diabetes, “population in need” is determined from the number of registered cases, which are likely to be greatly underestimated. Needs for anemia drugs and contraceptives are estimated from population data.

As shown in table 8, in 2017 MHIF reimbursed on average 1.7 prescriptions per registered hypertensive patient. While it is not clear from the database how long one prescription lasts, the amount is just a little over US\$4 equivalent. For diabetes and anemia, the two common and high-burden conditions in the country, coverage is much less. And for

contraceptives, less than 6,000 prescriptions were reimbursed in 2017, in a population of over 1.5 million women of reproductive age. Even though not all women of reproductive age would need contraceptives, the amount spent by MHIF was low by any standard.

**Table 8. MHIF’s Reimbursement under the ADP, Compared to Estimated Need**

Conditions	Reimbursed prescriptions	Amount (US\$ equivalent)	Estimated population in need	Prescription per person in need	Amount per person in need (US\$ equivalent)
Hypertension	284,434	705,153	169,412	1.68	4.16
Diabetes mellitus	1,140	13,328	56,448	0.02	0.24
Anemia	131,323	568,575	812,800	0.16	0.70
Contraceptives (injections and oral)	5,959	50,279	1,569,594	0.00	0.03

*Source:* (1) For MHIF’s reimbursement: ADP database; (2) For population in need: number of people with hypertension and diabetes represents the registered cases recorded by eHealth center; number of people with anemia is a sum of estimated number of children ages 0–5 with anemia and estimated number of women ages 15-49 with anemia (source: WDI); people in need of oral and injection contraceptives are women ages 15-49. All data are for 2017 except the estimated population in need for anemia drugs and contraceptives (2016).

*Note:* Exchange rate: US\$1 = 70 Kyrgyz soms.

The inclusion of specialized services (psychiatry, oncology, hematology, and cardiac surgery) under the Single Purchaser system in 2016 was not accompanied by adequate funding. For example, in 2016, there were roughly 4,200 surgeries, 1,500 patients on chemotherapy, and 600 patients on radiotherapy at the National Center for Oncology and Hematology—the only facility providing complete cancer treatment. While there is no accurate data on the number of cancer patients in the country, there are believed to be approximately 11,000 new cancer patients in the Kyrgyz Republic per year, far more than the number receiving treatment.<sup>3</sup> Similarly, according to the description of the SGBP, heart surgery for children under one year of age should be 100 percent covered by MHIF. However, in reality only 10 to 15 percent is covered.

A costing study of 35 inpatient services conducted by the World Bank (forthcoming) documented that MHIF pays below the median cost among studied hospitals for most services. Some of the differences are rather large, such as in the case of acute upper respiratory infection or pneumonia (Table 9). However, the study also revealed that MHIF does pay higher than the median level for some services and that there is a large cost variation among studied hospitals. These patterns suggest that there are issues beyond underfunding and further investigation is warranted into the hospital operation and MHIF’s pricing mechanism.

3. The estimate was based on WHO GLOBOCAN, which stated that the overall age-standardized cancer incidence rate is 205 in men and 165 in women per 100,000.

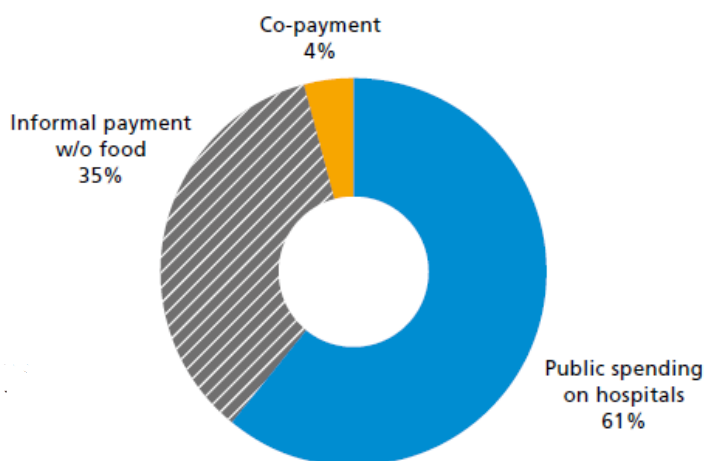
**Table 9. MHIF Payment and Median Cost of Certain Inpatient Services, 2018  
(Kyrgyz soms)**

Diagnosis and procedure	MHIF payment	Median cost
Acute upper respiratory infection, unspecified	4,745	3,310
Hepatitis A without hepatic coma	11,351	12,365
Type 2 diabetes mellitus with multiple complications	9,208	12,725
Pneumonia, unspecified	6,309	9,652
Classical cesarean section	7,515	8,043
Appendectomy	5,382	8,722
Cholecystectomy	6,510	10,489
Laparoscopic cholecystectomy	6,070	12,613

Source: World Bank (forthcoming) preliminary results.

The lack of an explicit list of covered benefits makes it impossible to cost the SGBP and estimate its financing gap. However, an attempt was made to estimate the share of informal payments in total hospital financing as a proxy for the hospital financing gap (Jacab, Akkazieva, and Kutzin 2016). The informal payment in this case includes not only “under the table” payment to health personnel but also extra payments for drugs and supplies that hospitals collected from patients. As shown in Figure 2 below, informal payments accounted for some 35 percent of total hospital financing in 2013, as opposed to only 4 percent generated by official copayment.

**Figure 2. Source of Inpatient Financing, 2014**



Source: Jacab, Akkazieva, and Kutzin 2016.

### **Generous exemption policy but no effective protection of the poor or against catastrophic payment**

The extensiveness of the list of population eligible for copayment reduction or exemption has been documented in several previous studies (Giuffrida, Jacab, and Dale 2013; World

Bank 2014). Indeed, as shown in Table 10 below, out of 933,623 total treated cases reported to the MHIF in 2017, nearly 432,000 cases belonged to the social categories that enjoyed 100 percent benefits. In all, MHIF had to pay the hospitals for patients in the social and medical categories in 74 percent of cases. This is also equivalent to 75 percent of total spending on treated cases (figure not shown). As can also be inferred from the table, 22 percent of full benefit categories are uninsured (137,970 out of 627,863). The uninsured group largely falls under the medical categories because most people in the social group already have insurance premiums covered by the government budget. Specifically, 66 percent of the treated cases receiving full benefits belong to the uninsured group. Social health insurance coverage in the Kyrgyz Republic is reported to be between 65 to 75 percent, and the policy to provide generous benefits to uninsured people based on a large number of medical conditions will not be helpful in boosting coverage further.

**Table 10. Number and Share of Beneficiary Groups in the Total Number of Treated Cases (2017)**

Patient categories	Insured	Uninsured	Total
No. of treated cases with 100% benefits, social	423,483	8,263	431,746
No. of treated cases with partial benefits, social	62,588	236	62,824
No. of treated cases with 100% benefits, medical	66,410	129,707	196,117
No. of treated cases with partial benefits, medical	39	26	65
Total no. of treated cases with 100% benefits	489,893	137,970	627,863
Total no. of treated cases with 100% or partial benefits	552,520	138,232	690,752
<b>Total no. of treated cases</b>	<b>708,579</b>	<b>225,044</b>	<b>933,623</b>
<i>Full benefit categories as % of total</i>	<i>69</i>	<i>61</i>	<i>67</i>
<i>Full and partial benefit categories as % of total</i>	<i>78</i>	<i>61</i>	<i>74</i>

Source: data from MHIF.

Note: The total number of treated cases does not include foreigners.

On the other hand, even setting aside the issue of budget constraint, the setup of the SGBP does not lend itself as an effective financial protection measure for several reasons:

- The SGBP does not contain an explicit poverty-targeting mechanism. Although many of the 30 social groups can generally be considered disadvantaged, the only category that is related to poverty is “Children under 16 years old from low-income families that have four or more children.” Thus, other people in low-income families are not eligible, unless they are included in other groups. Furthermore, MoLSD’s method to identify and certify low-income families is notoriously problematic. The SGBP has been documented to suffer from both significant inclusion and exclusion errors in poverty-targeting. A study conducted by WHO using 2010 KIHS data

revealed that an estimated 57 percent of the eligible were not poor, while an estimated 51 percent of the poor were not eligible for SGBP benefits (Jamal and Jacab 2013).

- The SGBP does not have a cap on the maximum amount of out-of-pocket payments patients are responsible for within a certain period of time (such as one year). The cap, which is typically known as a “stop-loss provision” is an arrangement that allows patients to stop paying out of pocket once their total payments have reached a specific limit, and it serves to protect patients from catastrophic expenditures. This mechanism helps lessen the impoverishing impact of medical care and exists in most developed health systems (Paris et al. 2016).

### **Weak information base for monitoring and management**

The information system for monitoring the actual manifestation of the benefit package suffers from several problems, most notably fragmentation and lack of sharing among key players, data inadequacy, and low quality.

#### ***Fragmentation and lack of sharing***

Currently, different levels of the health system use a spectrum of information systems that are not integrated and lack uniform standards. In many cases, for each specific task (reporting forms, indicators, etc.), a separate software product was created that was not integrated with other modules of the information system. As a result, each of the systems perform specific tasks at a health facility or health authorities and MHIF level, but does not use a full range of available clinical, statistical, and financial information for management decision making at every level of the health system.

In the PHC, medical documentation is primarily paper-based. Form No. 039y is used to populate the Republican eHealth Center (ReHC) database through software provided by ReHC. Data are transferred from the paper report forms to the offline electronic database by facility administrators. Currently, there is no mechanism for real time sharing of data from the ReHC to MHIF to perform purchasing of services.

A similar situation exists with the Patient Registration Database, which is held by ReHC. This database is the basis for capitation-based payments by MHIF. ReHC transfers data from this database to MHIF on a quarterly basis. Because of that, delays occur in the PHC payments related to the changed structure of the covered population.

#### ***Inadequate data***

One important subgroup of inpatients comprises those that are called “nonacute” or “chronic” inpatients in some countries. There is no separation between “acute” and “nonacute” care in the Kyrgyz Republic, and so, there is a shortage of information for health sector planning. If this kind of differentiated care is not recognized, it cannot be counted. The absence of good information means that it is difficult to ascertain whether

more nonacute inpatient care should be provided, or whether, for instance, more home nursing should be made available so that patients no longer have to remain in hospital.

Another problem is that there are no data on procedures performed at the PHC level. Such PHC procedure classification sorts patient data and clinical activities in the domains of General/Family Practice and primary care, taking into account the frequency distribution of problems seen in these domains. It allows classification of the patient's reasons for visit, problems/diagnosis managed, interventions, and the ordering of these data in an episode of care structure. Without a classification system, it is impossible for the MHIF to monitor the procedures that are being delivered to the population at the PHC level.

### ***Low-quality data***

The low reliability of health data acts as a further constraint on the ability to monitor the delivery of the SGBP. The main source of morbidity and mortality data is the routine health information system managed by the ReHC of the MoH. The reporting system uses the International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10) as the standard in recording morbidity and the cause of death. Some morbidity data for 2016 are presented in Table 11 below.

**Table 11. Structure of Morbidity in Adults and Adolescents, 2016**

<b>Diseases</b>	<b>Number</b>	<b>%</b>
<b>TOTAL</b>	<b>2,093,755</b>	<b>100</b>
Diseases of the circulatory system	298,290	14.2
Diseases of the digestive system	282,020	13.5
Diseases of the respiratory system	274,706	13.1
Diseases of the genitourinary system	235,402	11.2
Diseases of the nervous system	126,518	6.0
Diseases of the eye and its appendages	121,278	5.8
Diseases of the endocrine system	116,179	5.5
Diseases of the blood	88,308	4.2
Diseases of the musculoskeletal system	87,077	4.2
Injuries and poisonings	86,467	4.1
Diseases of the skin and subcutaneous tissue	77,593	3.7
Diseases of the ear and mastoid process	73,818	3.5
Pregnancy, childbirth, and the puerperium	72,115	3.4
Mental disorders	61,676	2.9
Some infectious and parasitic diseases	56,524	2.7
Neoplasms	29,826	1.4
Congenital anomalies	3,686	0.2
Symptoms, signs, and inaccurately marked	2,272	0.1

*Source:* data from ReHC.

As seen, Diseases of the circulatory system are responsible for 14.2 percent of the total morbidity in adults and adolescents. On the other hand, according to Global Health Observatory data, approximately 22 percent of the world's population has hypertension. This means that the reporting system in the Kyrgyz Republic is likely inaccurate, or that there are many undiagnosed patients, or both. A similar case applies to endocrine system diseases (which include diabetes). According to the STEP survey (WHO 2013), the estimated prevalence of diabetes among adults in the Kyrgyz Republic is around 6 percent. Yet only 116,179 cases are registered with endocrine system diseases for a total population of six million.

### **Lack of clear procedures and institutional arrangements for revision**

Despite what seems to be an established process, the revision of the SGBP was done in quite an ad hoc manner. For example, it was reported that the MoLSD and MoF almost never attended the meetings of the working group. There was no protocol or set methodology on how the working group should work; at times meetings were called at the last minute without preparation. The working group was also said to have too many participants, where no clear responsibility was assigned to each of them.

The information taken into account in the revision of the SGBP so far is mostly concerned with budget prognosis of the subsequent year. There has been no consideration of the burden of diseases, cost-effectiveness, budget impact, or costing information. Cognizant of the broad ambit of the SGBP, the MHIF attempted to make the paid services “more precise” in the 2015 revision. However, that attempt was not successful. The large number of beneficiary categories is reported to be a frequent topic in the SGBP discussion, but since that decision is politically sensitive and beyond the control of the health sector, no viable solution has been reached to date.

Particularly, the low capacity of the MoH in coordinating and leading the overall process seems to be the most important bottleneck in pushing through major changes in the SGBP. Due to the low salary scale of civil servants, the MoH has very high staff turnover. The SGBP is a complex issue, and there is concern that there will be no one left at the MoH who understands the SGBP. At the moment, the capacity of the MoH is seen as the most important challenge in revising the SGBP.

## 5. TOWARD A MORE PRO-POOR AND EXPLICIT BENEFIT PACKAGE

From the section above, it appears that several measures are needed to improve SGBP effectiveness in fulfilling its mission to ensure the right to health care for all Kyrgyz citizens. A non-exhaustive list of necessary actions could include the following:

- Simplify the SGBP and conduct campaigns to raise population awareness of their entitlements, and to improve transparency and accountability of the providers.
- Move gradually toward a more explicit version of the SGBP, in line with international trends and best practices.
- Refine the exemption groups and make it more explicitly poverty-targeted, also in line with international trends and best practices.
- Implement a whole array of measures to improve efficiency, reduce cost, and control price among providers and pharmacies.
- Improve the data system and generate more data for decision making, including both clinical and costing data.

Note that increasing funding for the SGBP is not an explicit recommendation. It is certainly the case that the benefit package is shallow, and funding is far from enough. However, a recommendation to increase funding without taking into account competing needs for resources in a poor country will not have much attraction. The recommendations here focus on measures that could be undertaken without significant additional budget; some will free up resources that can be used to deepen the benefits.

Increasing copayments is also not a recommendation. Without putting in place a well-functioning poverty-targeting mechanism, increasing copayments may cause greater harm to the poor and may exacerbate the differential benefits to the nonpoor population. More research is needed to understand the effects of higher copayments vis-à-vis the potential to raise additional revenue and the distributional impact on different population groups.

The following focuses on several of the most acute issues and offers an illustration of possible ways to proceed. The recommendation takes into account the particular context of the SGBP in the Kyrgyz Republic as well as experiences from other countries. In addition, some basic, universally applied principles for the definition and revision of the benefit package are provided in Annex 2.

### *MAKING POVERTY-TARGETING CENTRAL IN THE SUBSIDIZATION OF THE SGBP*

As shown above, two conflicting issues characterize the list of population eligible for copayment exemption or reduction: (1) the list is too broad and generous, given the



resource constraints; (2) on the other hand, the list does not provide adequate protection to the poor from the financial hardship of health care.

Importantly, though, this conflict is not unique to the Kyrgyz Republic. The World Bank's review of 24 UHC programs reveals that most of these have multiple target populations; most programs aim for the poor, but very few, if at all, are only for the poor—the “vulnerable” groups that often include mothers, children, the elderly, people with specific diseases, and people in special historical categories (Cotlear et al. 2015). Within the countries from the former socialist block in the Eastern Europe, it is common to find pensioners, veterans from World War II, or victims of Chernobyl among the exemption group. At the same time, across the programs reviewed by the Bank, there is an increasing recognition of the risk of medical impoverishment and efforts to improve the targeting of benefits for the poor (Cotlear et al. 2015).

For the SGBP in the Kyrgyz Republic, discussions often revolved around the possibility of shortening the list of categories eligible for subsidized care. Such proposals to remove certain eligible groups has proved to be politically challenging, even though the reality of budget constraints and the need to better protect the poor are both well understood.

A practical option that could help address both problems could be to use poverty status as a filter for eligibility among the social and medical categories. The following example from Romania illustrates the idea (Box 2).

**Box 2. Romania: Categories of Insured Persons Who Are Exempted from Copayments in Inpatient Treatment**

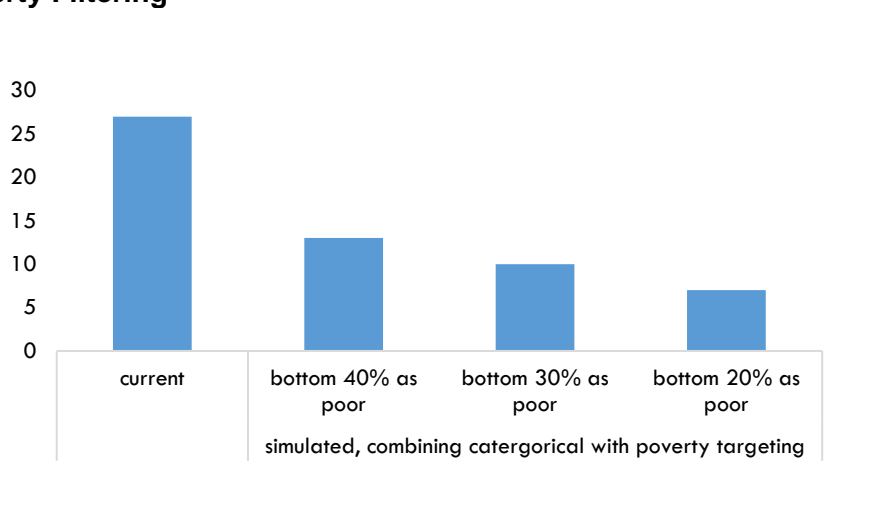
- Children up to 18 years old; youngsters aged between 18 and 26 who are high school students, high school graduates for up to three months after graduation, students or apprentices, **provided they do not have income from work.**
- Sick people covered by the national programs of the Ministry of Health, for medical services related to their main disease, **provided they are deprived of income of any source.**
- Pensioners **whose income does not exceed lei 740 (€163) per month.**
- Pregnant women and women who have just given birth, for medical services related to pregnancy, **and those who have no income or have incomes below the minimum gross wage** for all medical services.

*Source:* MISSOC, the Mutual Information System on Social Protection 2016.

To illustrate the idea, a simulation was performed using 2014 KIHS data. In the figure below, the first bar represents the whole eligible population as currently defined, based on the 30+16 categories. Note that this is a hypothetical figure because the survey does not allow for a full identification of all categories. Using consumption expenditure, three “poor” groups were estimated, based on different criteria: bottom 40 percent of the population, bottom 30 percent, and bottom 20 percent (the poorest quintile). If one combines the

current eligible criteria (30+16) with poverty status, the size of the group eligible for SGBP copayment exemption or reduction decreases, as shown in bars 2, 3, and 4 in the figure.

**Figure 3. Hypothetical Scenarios of SGBP Exemption, Eligible Population Size with Poverty Filtering**



Source: Authors, based on incomplete identification of beneficiary groups, KIHS data 2014.

The above is a hypothetical example; far more work must be done to derive a precise estimate, with consideration of each and every current category. However, it does provide a practical option to operate within the budget constraint and to navigate the political pressures associated with the exemption groups.

The Kyrgyz Republic could consider a stop-loss clause to help protect against catastrophic payment. For reference, examples of various caps on out-of-pocket payments from OECD countries are shown in Annex 3. Implementing the stop-loss policy requires a developed data system that would help MHIF to track individual patient’s benefits and cumulative copayment. The MHIF’s hospital database is detailed enough, and only minimal revisions will be required to enable the administration of the stop-loss provision if it is to be adopted.

***BUILDING ON THE EXISTING EXTENSIVE CLINICAL GUIDELINES AND CARE PATHWAYS TO DEVELOP A DETAILED LIST OF SERVICES INCLUDED IN THE SGBP***

The Kyrgyz Republic has a large number of clinical guidelines and care pathways that were developed early on.<sup>4</sup> Since 2002, approximately 380 clinical guidelines and 200 care

<sup>4</sup>. Clinical guidelines: documentation that advises on the clinical management (including screening, preventative, diagnosis, treatment, prevention, rehabilitation and palliation) of individuals in a particular setting for a particular disease area/condition.

Care pathway: multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals

pathways have been developed. Clinical guidelines and care pathways are divided into groups based on the specialty, including but not limited to obstetrics and gynecology, allergology, gastroenterology, hematology, dermatology, etc. The majority of guidelines provide guidance on maternal and child health (29.2 percent), followed by infectious and parasitic diseases (27.7 percent). All guidelines are based on international evidence. For example, to develop guidelines for uncomplicated pregnancy, multiple pregnancy, acute pyelonephritis in pregnancy, spontaneous miscarriage, premature labor, and infections during pregnancy, the following international sources/journals were used:

- National Institute for Health and Care Excellence clinical guidelines
- Centers for Disease Control and Prevention
- The World Health Organization Reproductive Health Library
- The Journal of Infectious Diseases
- The Journal of Reproductive Medicine
- American Family Physician
- The Journal of the American Medical Association
- Prenatal Diagnosis
- American Journal of Perinatology
- Obstetrics & Gynecology
- Birth Defects Research
- Clinical and Molecular Teratology

An option for developing a more explicit version of the SGBP could be to use the clinical guidelines and care pathways to concretize personal health services along a full continuum of care. This starts with documenting all services currently provided in the public sector as per national policy, by level of care. The structure of this SGBP can comprise a database that lists all interventions. The primary policy documents used to populate such database could be clinical guidelines and care pathways. Clinical guidelines can have a substantial influence on clinical decision making, and also contribute to health policies that determine availability of technologies and the type and method of health care provided to patients, with consequences for patient outcomes and access to care, health system costs, and resource use. Every intervention reflected in the clinical guidelines and care pathways could be captured in the SGBP. Such a framework should ultimately enable the description and costing of services at differing levels of granularity such that it could be used to inform the full range of health sector stakeholders. In this way, development of integrated health care would be supported.

Similarly, one could build on the existing system of the diagnosis related groups (DRGs) (the latest was published in 2015) and other guidelines to develop a concrete list of services, procedures, or drugs to be included in the SGBP.

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involved in the patient care are defined, optimized, and sequenced either by hour, day (acute care), or visit (homecare).

Some illustrations of using guidelines and a DRG system to develop an explicit list of services to be included in the SGBP are provided below.

**(i) Uncomplicated pregnancy**

A collection of clinical protocols for uncomplicated pregnancy, multiple pregnancy, acute pyelonephritis in pregnancy, spontaneous miscarriage, premature labor, and infections during pregnancy was published by the MoH in 2013. This guideline lists every health intervention that the current national policy dictates should be provided under antenatal care for uncomplicated pregnancy. It includes six antenatal visits. Table 10 below presents an example of how data for antenatal visits can be separated into six categories: name of the program (condition), care provider, procedures, laboratory tests, prescribed drugs, and coverage. This provides a framework for a systematic approach to the creation of a standard set of health service benefits that are provided efficiently and effectively.

**Table 12. Translating the Guideline for Uncomplicated Pregnancy to an Explicit List of Services**

Program	Care provider	Procedures	Laboratory tests	Prescribed drugs	Coverage
<b>1. Pregnancy</b>					
1.1. Antenatal care for uncomplicated pregnancy					
1.1.1. First visit	FMC	Anamnesis Clinical examination Counseling Ultrasound	Hemoglobin; blood group and Rh factor; Urine protein test; screening for bacteriuria; vaginal smear only in the presence of clinical symptoms of vulvovaginitis; HIV testing; RW; HBsAg; screening for rubella	Folic acid, Potassium iodide, Aspirin, Calcium carbonate	All pregnant women
1.1.2. Second visit	FMC	Anamnesis Clinical examination Counseling Ultrasound	Urine protein test; Screening for Down's Syndrome (women over 35 or if the previous child has chromosomal abnormalities)	Potassium iodide, Aspirin, Calcium carbonate	All pregnant women
Etc.					
1.2. Management of specific clinical conditions					
1.2.1. Diabetes in pregnancy	TBD	TBD	TBD	TBD	TBD
Etc.					

Source: Authors

Note: FMC: Family medicine center; TBD = To be determined.

In this way, a very explicit list of benefits can be created. It is also possible to use clinical guidelines to create a less explicit list of benefits, as we show bellow.

**Table 13. Translating the Guideline for Uncomplicated Pregnancy to an Explicit List of Services, a Simplified Version**

Program	Care provider	Medical management	Surgical management	Coverage
<b>1. Pregnancy</b>				
1.1. Antenatal care for uncomplicated pregnancy	FMC	6 antenatal visits, basic laboratory tests, medications	-	All pregnant women
1.2. Ectopic pregnancy	Hospital	Ultrasound, laboratory tests, medications	Laparoscopic surgery	All pregnant women
Etc.				

Source: Authors

Note: FMC: Family medicine center.

**(ii) Procedures on femur in emergency medical service**

Currently, DRG number 810 (procedures on femur) describes a list of procedures provided by emergency medical service (EMS) for injury of femur, as below:

**Table 14. DRG Code and Procedures for Femur**

DRG Code	Procedure Code	Name
810		Procedures on femur
810	78.15	Application of external fixator device, femur
810	79.45	Closed reduction of separated epiphysis, femur
810	79.65	Debridement of open fracture site, femur

Source: Authors

This list can be translated in to the SGBP in a similar way, as illustrated with the uncomplicated pregnancy.

**Table 15. Translating the DRG for Femur to an Explicit List of Procedures**

Program	Care provider	Procedures	Laboratory tests	Prescribed drugs	Coverage
<b>1. Emergency Medical Services</b>					
1.1. Procedures on femur	Outpatient EMS Inpatient EMS	Application of external fixator device Closed reduction of separated epiphysis Debridement of open fracture site			All citizens
Etc.					

Source: Authors

### (iii) Outpatient drugs

Outpatient drug benefit includes free-of-charge drugs list and subsidized drugs list. It includes concentrates of factors VIII/ IX for children under 16 with hemophilia.

**Table 16. Current Coverage of Concentrates of Factors VIII/IX for Children with Hemophilia**

Disease	Drug or medical device	Rate of distribution per patient per year
Children under 16 with hemophilia	Concentrates of factors VIII/ IX	6,500 I.U.

*Source: Authors*

As currently regulated, the total quantity per year is 6,500 I.U. for each child, regardless of hemophilia severity. However, the need for concentrates of factors is different depending on the level of severity, which is based on percentage of normal factor activity in blood. Therefore, outpatient drug benefit may be refined to differentiate concentrates of factor VIII/ IX availability, based on severity of hemophilia (mild, moderate, severe). Similar solution can be applied to some other diseases (drugs) included in outpatient drug benefits.

As seen from the above three examples, the proposed strategy for SGBP revision is built as far as possible on available resources and knowledge. Furthermore, this principle will not only make the SGBP more explicit and precise, it will also help enforce adherence to guidelines and referral pathways and facilitate further development of the guidelines themselves. Eventually this process will inform the areas subject to Health Technology Assessment (HTA) and help build capacity in this aspect as well.

### *DEVELOPING AN APPROACH TO ONGOING REGULAR REVISIONS OF SGBP*

The SGBP process should be considered continuous and comprise learning, adjusting, and starting over. It is therefore recommended that a permanent structure responsible for ongoing regular revisions of SGBP be established. The need for a standardized and evidence-based approach to clinical guideline development has already been recognized in the Kyrgyz Republic by the establishment of an Evidence Based Medicine Unit within the MoH. Given the direct link between guideline development and SGBP, the MoH would be a natural home for such unit. It should include the current Evidence Based Medicine Unit as well as new HTA capacities to support MoH with decision making and to inform adjustments to the SGBP on an ongoing basis. The core remit of this unit will be, as follows:

- To lead the process of SGBP revision, coordinating among different stakeholders.
- To lead and coordinate the systematic development of clinical guidelines and care pathways.

- To review new and high-priority technologies (that have been selected through a transparent topic selection process) with consideration of their costs, benefits, equity, and social impact, compared to current technologies and/or current practices using the best available evidence.

This structure should serve as the secretariat for the SGBP working group. This working group should be established as a permanent body. It should include not only representation of the MoH, MHIF, MoF, and MoLSD, but also professional organizations (e.g., medical chamber), scientific organizations (e.g., medical academy), and patient associations. All stakeholders should be engaged to define a proposal outlining the remit, structure, and functions of a SGBP working group. The work of the SGBP secretariat and working group should be focused on the ongoing regular revisions and costing of SGBP.

The SGBP Unit should also be responsible for developing and upholding key components of clinical guideline development, which include robust processes for topic selection, guideline development, publication/implementation, and review. The final list of clinical guidelines (with appropriate content and of acceptable methodological quality, as determined by an agreed accreditation process) should then be compared to the proposed SGBP to identify the gaps in up-to-date clinical guidance for the delivery of the SGBP.

The national repository of clinical guidelines should be strengthened with HTA. Given the direct link between guideline development and HTA, the Evidence Based Medicine Unit should also be a national coordinating center for HTA.

Ultimately, the establishment of an HTA unit will save more lives and ensure a sustainable SGBP by undertaking the following:

- Prioritizing interventions with the highest value and quality
- Reducing wasteful expensive, unnecessary and unsafe care
- Realizing resources, by improving efficiency to enable SGBP to reach more people and ensure greater equity

In summary, a roadmap for SGBP reform would include the following:

- Development of a legal framework that defines a SGBP-related decision-making process and institutional structures responsible for the revisions of SGBP
- Creation of the SGBP unit within the MoH, with full-time staff and a plan for staff capacity-building in the related areas of the SGBP
- Development of a detailed implementation plan

These recommendations and associated activities are inextricably linked, and the success of their implementation will depend on a thorough and consultative development process. This will provide a strong foundation for the incremental development of the explicit service entitlements for all levels of care.

## **6. CONCLUSION**

The government of the Kyrgyz Republic is seeking to provide high-quality, accessible, and affordable health services, and has the ambition of providing universal coverage for the population. The SGBP is an essential instrument in this endeavor. The primary purpose of the SGBP should be to make the most cost-effective allocation of scarce resources to address the country's disease burden, whilst recognizing the limits to available financial resources and the need to promote equity of access to services. Despite the expectations, the current SGBP fails to deliver on its important mission to achieve effective universal health coverage.

Going forward, the government of the Kyrgyz Republic has determined to make significant improvements to the SGBP. This will be a major undertaking that requires concerted effort from different stakeholders inside and outside the health sectors. Besides technical solutions, political support for SGBP revision will ultimately decide whether the country can arrive at a package that goes beyond mere declarations to deliver real benefits to the population. It is expected that the information in this paper will be helpful to the government of the Kyrgyz Republic to fulfil this important undertaking.



## REFERENCES

- Cotlear, D., S. Napal, O. Smith, A. Tandon, and R. Cortez. 2015 “Going Universal: How 24 Developing Countries Are Implementing Universal Health Coverage from the Bottom Up.” Washington, DC: The World Bank.
- Giedion, U. I. Tristao, R. Bitrán, O. Cañón. 2013. “Making the Implicit Explicit: An Analysis of Seven Health Benefit Plans in Latin America.” In *Health Benefit Plans in Latin America: A Regional Comparison*, ed. U. Giedion, R. Bitrán, and I. Tristao. Washington, DC: Inter-American Development Bank.
- Giuffrida, A., M. Jacab, and E. Dale. 2013. “Toward Universal Coverage in Health: The Case of the State Guaranteed Benefit Package of the Kyrgyz Republic,” UNICO Studies Series 17. The World Bank, Washington D.C.
- Amanda Glassman, Ursula Giedion, and Peter C. Smith. 2017. “The Health Benefits Package. Bringing Universal Health Coverage from Rhetoric to Reality.” In *What's In, What's Out: Designing Benefits for Universal Health Coverage*, ed. Amanda Glassman, Ursula Giedion, and Peter C. Smith. Washington, DC: Center for Global Development.
- González-Pier, Eduardo. 2017. “Revisiting and Reformulating. How Explicit Benefit Packages Have Helped Mexico Move toward Universal Health Coverage.” In *What's in, What's Out: Designing Benefits for Universal Health Coverage*, ed. Amanda Glassman, Ursula Giedion, and Peter C. Smith. Washington, DC: Center for Global Development.
- Government of the Kyrgyz Republic. 2015. “The State Guarantee Program for the Provision of Health Care to the People.” Resolution № 790, November.
- Ibraimova, A. B. Akkazieva, G. Murzalieva and D. Balabanova “Kyrgyzstan: A Regional Leader in Health System Reform.” In *Good Health at Low Cost 25 Years on. What Makes an Effective Health System?* ed. D. Balabanova, M. McKee, and A. Mills. London: London School of Hygiene & Tropical Medicine.
- Jamal, S., and M. Jakab. 2013. “Who Benefits from the State Guaranteed Benefit Package in Kyrgyzstan?” WHO Health Financing Policy Paper Series, Geneva.
- Institute of Medicine. 2012. “Essential Health Benefits: Balancing Coverage and Cost.” Washington, DC: The National Academies Press.
- Jacob, M., B. Akkazieva, and J. Kutzin. 2016. “Can Reductions in Informal Payments Be Sustained? Evidence from Kyrgyzstan 2001–2013.” Health Financing Policy Papers, World Health Organization, Geneva.
- Kutzin, J., A. Ibraimova, N. Kadyrova, G. Isabekova, Y. Samushkyin, and Z. Kataganova 2002. “Innovations in Resource Allocation, Pooling and Purchasing in the Kyrgyz Health System.” Policy Research Paper No. 21. World Health Organization and Health Policy Analysis Center, Bishkek,
- Mandatory Health Insurance Fund (MHIF). 2018a. Budget for 2018
- Mandatory Health Insurance Fund (MHIF). 2018b. The State Programs of the Subsidized Drugs Supply.
- Manjjeva, E., U. Narmanbetov, N. Kadyrova, and M. Jakab. 2007. “Analysis of the Medium-Term Financial Sustainability of the State Guaranteed Benefits Package.” Policy Research Paper No. 43, World Health Organization and Health Policy Analysis Center, Bishkek.

- Mutual Information System on Social Protection. 2016. <http://www.missoc.org/MISSOC/>. Accessed September 15, 2016.
- O'Dougherty, S., and B. Akkazieva. 2016. "Integration of Specialized Services into SGBP Including Link to Strengthening Purchasing Arrangements." Technical report, World Health Organization, Geneva.
- Paris, V., E. Hewlett, J. Alexa, and L. Simon. 2016. "Health Care Coverage in the OECD Countries in 2012." OECD Health Working Papers No. 88, OECD, Paris.
- Republican eHealth Center (ReHC). 2016. Data extract from routine information system.
- World Bank. 2014. "Kyrgyz Republic: Public Expenditure Review Policy Notes." Health. Report No. 88979, World Bank, Washington, DC.
- World Bank. 2019 "Identifying Bottlenecks in Service Delivery: Diabetes Care in the Kyrgyz Republic." Technical report, World Bank, Washington, DC.
- World Bank. Costing of Inpatient Services. Draft report (forthcoming).
- World Health Organization. 2013. STEPwise Approach to Surveillance (STEPS). Unpublished report, Geneva.

## ANNEXES

### ANNEX 1. CATEGORIES OF POPULATION ELIGIBLE FOR COPAYMENT REDUCTION AND EXEMPTION

#### **Categories of citizens entitled to free health care at the outpatient level and in the hospitals based on their social status:**

1. Participants in World War I
2. Disabled soldiers of World War I and the Batken events
3. Citizens injured and disabled during the fight against international terrorism
4. Citizens awarded the orders and medals of the USSR for the selfless labor and honorable military service on the home front during World War I
5. Former prisoners of the concentration camps
6. Survivor of the siege of Leningrad
7. Labor veterans over 70 years old
8. Persons awarded the Order of "Baatyr ene" and the Order "Heroine Mother"
9. Citizens subjected to illegal forced mobilization in the working columns (labor army) during World War I and subsequently rehabilitated
10. Heroes of the Soviet Union and persons awarded the third degree Order of Glory
11. Heroes of Socialist Labor
12. Citizens awarded the highest distinction "Kyrgyz Respublikasynyn Baatyry" and persons awarded the first degree Order of "Manas"
13. Participants of the military operations in the territory of other states
14. Citizens affected by the Chernobyl Nuclear Power Plant accident
15. Persons with disabilities who have been wounded or injured in the performance of duties of military service
16. Family members of the dead or missing persons (parents) upon reaching retirement age; if the deceased was the only child; or for children under age 18 years, who suffered serious, less serious, or light injuries confirmed by an adequate medico-legal examination report; persons with recognized disabilities due to injuries sustained in the events of March 17, 2002 in Aksy rayon of Jalal-Abad oblast; events of April 6, 2010 in Talas oblast; events of April 7, 2010 in the cities of Bishkek and Naryn; events of May 13, 14, 19, 2010 in Jalal-Abad, and events in June 2010 in the cities of Osh, and in Osh and Jalal-Abad oblasts.
17. Persons with disability, groups I and II, assigned as a result of work injury, occupational, or general disease
18. Persons with disabilities of sight and hearing
19. Person handicapped from birth
20. Children with disabilities under the age of 18 years
21. Children under 5 years
22. Orphans living in the state children's homes, family-type children's homes (foster families), and boarding schools for orphans and children left without parental care

23. Citizens who live in nursing homes for the elderly and in homes for persons with disabilities
24. Citizens subject to active military service conscription, referred by the military medical commission for medical examination at the outpatient level or to hospital treatment
25. Conscripts for whom the departmental health organizations cannot provide qualified medical assistance during the period of military service
26. Persons living with HIV/AIDS
27. Children under 16 years from large low-income families with 4 or more minor children (students of educational institutions before they complete their education, but not beyond the age of 18), upon presentation of the relevant certificate issued by the social development agencies
28. Pensioners over the age of 70
29. Persons under preliminary investigation, as well as those serving sentences, in the event of emergency conditions that threaten their lives in case of failure to provide medical care for them in the medical services of the penitentiary system, the detention facility of the State National Security Committee of the Kyrgyz Republic, or the temporary detention of the Ministry of internal Affairs of the Kyrgyz Republic.
30. Graduates of children's homes, boarding homes, left without parental care, under the age of 23 years

**Categories of citizens entitled to free health care based on the clinical indications of the underlying disease in the outpatient and inpatient facilities**

1. Women registered with pregnancy
2. Women with abnormal pregnancy during hospitalization (for underlying diagnosis)
3. Women admitted for abortion for social or medical reasons
4. Women admitted for childbirth
5. Women with obstetric complications during the 10 weeks after childbirth
6. Patients with TB
7. Patients with bronchial asthma
8. Patients with cancer in the terminal stage
9. Patients with mental disorders (paranoid schizophrenia, chronic delusional disorders, or affective disorders of various origins)
10. Patients with epilepsy
11. Diabetics
12. Patients with diabetes insipidus
13. Patients with particularly dangerous and quarantine infections (typhoid, paratyphoid, anthrax, plague) and persons who had contact with them and the possibility of infection
14. Hydrophobe patients and persons who had contact with them and the possibility of infection
15. Patients with meningococcal meningitis
16. Patients with hemophilia

## **ANNEX 2: KEY PRINCIPLES FOR DEFINING AND REVISING THE HEALTH BENEFIT PACKAGE**

In developing or analyzing a health benefit package, many different aspects should be taken into account, and many questions should be answered. Some of these questions are listed below. They are meant to provide a framework of relevant questions, though there may be other relevant questions that are not included here.

### **Impacts on Individual Well-being**

What positive impacts does the intervention provide to those who receive it?

- What kinds of health gains are associated with the intervention and how likely are they?
- How large and/or important are these health gains for those who will experience them?
  - Is there a subset of people who are more likely to experience greater benefits from the intervention?
- Will these health gains have other positive effects on well-being beyond health?

What negative outcomes may occur if this intervention is not covered?

- How likely are these negative outcomes?
- How severe are these outcomes?
- How long will they impact the well-being of those affected?
  - Is there a subset of people who may be more likely to experience severe and/or prolonged adverse outcomes if the intervention is not covered?

Are there any groups of individuals who are likely to have adverse reactions to or complications from this intervention, even if most will benefit from it? (e.g., patients with comorbidities where there are foreseeable adverse drug interactions; patients with a particular genetic marker that would provide a contraindication)

- What can be done to avoid harm among these patients? What could be offered as an alternative intervention?

### **Population Health Gains**

How well does this intervention support high-priority public health goals and objectives?

- Will this intervention reduce a high disease burden among the population? How significant are the likely impacts?
- Will there be additional health benefits for those not directly receiving the intervention? Are there positive health externalities?
- How durable are the impacts of the intervention? (e.g., a vaccine that will offer lifelong protection for the immunized cohort vs. an intervention that must be given continuously to sustain impact)

What, if any, negative population health consequences could arise if the intervention is not provided?

### **Equity**

How well does this intervention align with equity objectives?

Does the intervention under consideration serve populations that are disadvantaged in one or more dimension of their well-being? Does it help address disparities between groups, such as by income, gender, geographic location, age, education, etc.?

If so, in what ways?

Does the intervention under consideration serve populations that are already advantaged? Will coverage of these services exacerbate inequities across the population?

If so, in what ways?

### **Respect for Clinician Judgment**

How might restricting coverage of this intervention negatively affect care providers' ability to exercise their discretion in delivering appropriate care? How stringent are these limitations? Are the restrictions reasonable and justifiable?

Are there specific ways in which not covering this intervention might negatively impact the provider-patient relationship in the context of limited care decisions? (e.g., if public providers are unable to offer something that is widely covered by private insurers, could that lead to distrust between patients and providers—particularly in cases where many doctors work in both public and private clinics?)

Does the community of practice (e.g., medical associations, international and national clinical guidelines) support adoption of this intervention?

If so, is this intervention the best among available options for the local context, taking into consideration affordability and efficiency, health system capacity, and training level of providers?

If this intervention is not supported by evidence-based practice guidelines (or even recommended against by them), yet remains common practice among care providers, what if anything can and should be done to engage providers advocating for it?

### **Evidence-informed Decision Making and Evidence Generation**

- What evidence exists to inform assessment for each of these considerations? How robust is that evidence? Can reliable conclusions be drawn from the current sources of information?

- Where there are gaps, what kinds of evidence should be pursued to inform the assessment?
- Which, if any, indicators should be collected routinely to inform ongoing coverage decisions?

### **Fair Processes and Procedures**

- Whose interests are most affected by the decision to include or exclude this intervention? Who are the relevant stakeholders?
- How, when, and for which considerations should these stakeholders be included in the ethics assessment?

Benefit package design is a multistep and dynamic process, which should start with setting clear goals and general criteria for the selection of disease control priorities and services and products within each priority. Given the whole inventory of potential candidates for inclusion or exclusion, decisions should be made on how to classify services into different categories with rules to define priority inclusions or exclusions, or types of technologies. In this way the structure, language, and granularity of SGBP will be defined.

Priority-setting is essentially about weighing up the costs and benefits of an intervention in relation to the burden of disease, the budgetary envelope, and societal preferences. It is necessary even in the most well-resourced environment because all health systems face some form of constraints.

Once proposals are prepared, a next step is to establish a mechanism that will allow for discussion and deliberation around evidence and proposals as an input to making a recommendation for inclusion or exclusion. While deliberation is more commonly applied as part of Health Technology Assessment<sup>5</sup> (HTA), there are good reasons to consider including a process of deliberation around the entire portfolio of SGBP services and its subsequent adjustment as well. In many settings, deliberation ends with a recommendation to policy makers on the individual services or portfolio of services that are to be included in the SGBP, but fails to connect the recommendation with decision making. In an ideal process, there is an obligation to consider the appraisal and its recommendations in decision making on whether services are included or excluded for public subsidy.

Decision-making process should include the following:

- **Identification and prioritization** of the specific topics or technologies that are to be considered. It is important to establish topic prioritization criteria to effectively target the most relevant health policy decisions.

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5. Health technology assessment (HTA) refers to the systematic evaluation of properties, effects, and/or impacts of health technology. It is a multidisciplinary process to evaluate the social, economic, organizational, and ethical issues of a health intervention or health technology. The main purpose of conducting an assessment is to inform policy decision making.

- **Analysis** is the technical evaluation phase and involves generating evidence about the likely implications of policy decisions, usually in the form of a cost-effectiveness analysis.
- **Appraisal** is the consideration of the evidence produced at the analysis phase and provides an opportunity for social and scientific value judgments that form assumptions made in the analysis to be tested and challenged.
- **Decision making** is the point where the health policy decision is made. The decision-making phase provides an opportunity to incorporate findings of the analysis, judgments of the appraisal, and any other criteria that are considered relevant, such as specific issues relating to unmet need, previously disadvantaged populations, equity implications, non-health effects of a technology, and even wider macroeconomic and industrial policy considerations.
- **Implementation activities** support the uptake of health policy decisions and improve the potential for the health policy decision to have an impact on practice and patient care. Implementation activities should be linked to initiatives for clinical audit and quality indicators, regulation and accreditation frameworks, payment incentive structures, and education and communication resources.



### ANNEX 3. EXAMPLES OF CAP ON OUT-OF-POCKET PAYMENT, OECD COUNTRIES

Country	Annual cap for cost-sharing
Australia	<p>“Extended Medicare Safety Net”: cap on out-of-pocket costs for outpatient services covered by Medicare (i.e., services provided by GPs, specialists, private clinics, and private emergency departments). Beyond an expenditure threshold (which is indexed annually), Medicare pays 80% of out-of-pocket costs. Low-income individuals qualify for the Safety Net at a lower threshold.</p> <p>The pharmaceutical safety-net threshold for general patients is currently \$A 1,390.60 (US\$950) for the calendar year, while the concessional patient threshold is \$A 345.00 (US\$242). After reaching the threshold, general patients usually pay \$A 5.90 (US\$3.93) for each prescription for the remainder of the calendar year, while concessional patients receive prescriptions free of charge.</p>
Austria	Maximum threshold of 2% of the annual income.
Belgium	Annual cap on cost-sharing.
Chile	Annual cap on cost-sharing, plus a cap of 30% of annual household income for conditions or treatments in the GES program.
Czech Republic	Annual cap on all cost-sharing.
Denmark	Annual cap of Dkr 3,710 (US\$472 for pharmaceuticals). Other services of medical diagnostic and curative care are virtually free of charge.
Finland	Annual copayment cap of €636 (US\$677) in 2012 on cost-sharing for health services provided by municipalities.
Germany	Copayments are capped at 2% of gross household income, reduced to 1% for the chronically ill.
Hungary	Entitlement to free pharmaceuticals for those whose medical expense exceeds 10% of the minimum pension (for households with income per capita < minimum pension = €100 in 2010).
Iceland	Cap on cost-sharing for outpatient primary care, outpatient specialist contacts, clinical laboratory tests, and diagnostic imaging.
Ireland	Annual cap on inpatient care, primary care, and pharmaceuticals.
Israel	Annual cap on inpatient and outpatient primary care.
Japan	Monthly copayment cap, depending on age and income.
Korea, Rep.	Expense limit for all cost-sharing is based on the average health insurance fee per year.
Luxembourg	Annual cap on all cost-sharing is based on the average health insurance fee per year.
New Zealand	Annual cap for pharmaceuticals; after a family has paid for 20 items, all medicines are free of charge for patients. In addition, copayments by patients enrolled at GP practice offering the VLCA scheme are capped (to \$NZ 17 [US\$11.49] for an adult).
Norway	Annual cap for the combination of expenses on pharmaceuticals, consultations with physicians in the primary health care sector, psychologists, and psychiatrists, outpatient services in hospitals, laboratory tests, x-rays set at Nkr 2,040 (US\$344) in 2013.
Portugal	Annual cap on copayments for low-income elderly people for dental prosthesis and eyeglasses.
Sweden	<p>Annual cap for all cost-sharing requirements.</p> <p>Annual cap on copayments for pharmaceuticals, set at SKr 1,800 (US\$203).</p>

*Source:* OECD Health System Characteristics Survey 2012 and Secretariat’s estimates; Baji et al. 2011 (reproduced from Paris et al. 2016).

*Note:* GP = General practitioner; GES = Garantías Explícitas en Salud (Explicit Health Guarantees); VLCA = Very Low Cost Access Scheme.



The Kyrgyz Republic has made significant steps in reforming the health system through successive National Health Programs implemented over the last 20 years. One of the major achievements of such reforms was the establishment of a single-payer national health insurance and a basic benefit package. The State Guaranteed Benefit Package (SGBP) provides free basic health services at the primary care level for the whole population, and inpatient care with nominal copayments or no fee for certain groups.

Even though the principles of the SGBP contain elements of international good practice, the SGBP has hardly changed since it was established. At the same time, many changes have taken place within and outside the health system, exerting mounting pressure for the SGBP to adapt to the new disease burden and meet the population's expectations within the context of budget constraints.

The current paper provides a critical assessment of the Kyrgyz Republic's basic health benefit package. It reveals a number of issues in the actual benefits delivered to the population as opposed to the generous promise of the statutory package. Some important limitations include lack of clarity, persistent funding gap, the large number of fee exemption categories given the resource constraints, and at the same time lack of an effective mechanism to protect the poor. Most importantly, there is no systematic arrangement in place to ensure a regular evidence-based process to revise the benefit package.

The paper proposes several measures that could guide the process of SGBP revision, taking into account the particular Kyrgyz context and building on international experiences. It is expected that information from the paper will be useful not only for Kyrgyz stakeholders, but also for other countries in making the benefit package an effective instrument for achieving universal health coverage.

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