BUDGET STRUCTURE REFORMS AND THEIR IMPACT ON HEALTH FINANCING SYSTEMS: LESSONS FROM KYRGYZSTAN

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World Health Organization

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EXECUTIVE SUMMARY

Since its independence, Kyrgyzstan's has shown commitment to the goals of the universal health coverage. It has led to documented improvement in financial protection and access to health care. It has also improved significantly efficiency in use of resources and equity of resource distribution. As a result, it has been recognized as a regional leader in health system transformation. The creation of a national pool, establishment of a separate purchaser with a unified information system, authority to contract providers and a shift from input- to output-based payments were important policy instruments in achieving these improvements.

However, the reform process has not been easy: the health sector struggled for a number of years with rigid input-based controls which dampened the effect of new output-based provider payment methods. Input-based budgeting was one of the key factors in incomplete process of downsizing large hospital infrastructure. Also, the provider payment reforms did not create the expected incentives for provider managers to optimize their input mix to improve efficiency over time because MOF's methods for formulating the MHIF budget ceiling created systemic disincentives. For several years budgeting reforms were stuck in a pilot stage and remained a paper exercise done for development partners more than internal stakeholders. While significant technical assistance was put into introducing programme budgeting, until there was ownership within the Ministry of Finance of these reforms, they were abandoned as soon as projects financing them would end. In the meantime, health sector continued to struggle with the misalignment which existed between the output-based payment logic in the health sector and the prevailing input-based approach to budgeting.

Recently, the country started making visible changes in its budgeting process, gradually shifting from input controls to accountability for results in the health sector as part of the broader public finance reforms. Specifically, according to the general law on budgets (the Budget Code) programme classification should become the main basis for appropriation with performance indicators integrated into the regular budget cycle. While in 2019 annual budget law continued to use administrative and economic classifications to regulate appropriation and execution, these are applied at a higher level (i.e. avoiding detailed prior controls) and are better aligned with provider payment methods.

However, for the effects of these changes to be fully realized in practice, the reforms cannot stop here. Ministry of Finance should review the principles and the basis on which budgets are formed to ensure that programmes receive appropriate funding to deliver on the policy commitments and achieve the set targets. Ministry of Health, Ministry of Finance and the purchaser should jointly review programme and sub-programme definitions to allow improved prioritization of spending based on these programme. Where both Ministry of Health and purchaser budgets are supporting the same objectives,

there is an argument for aligning programme structure across the health sector. Ministry of Finance should articulate a clear policy on how performance targets and indicators will and will not be used, and communicate this clearly to budget and programme managers in line Ministries, its own staff, staff involved in inspecting/auditing, and legislators – to address the legacy of concern about punitive use of performance measurement. Purchasing agency is now fulfilling the role previously played by the Treasury of approving spending by line-items of providers. However, whether it has the capacity to do so is yet to be determined. The authority granted to the purchasing agency should be balanced with strong accountability mechanisms and strengthening of its financial management capacity. Finally, programme budgeting will not work unless MOF and development partners invest in complementary efforts to strengthen financial management capacity in healthcare providers.

1. INTRODUCTION

Kyrgyzstan has made strong progress in health financing reforms and was among the first countries in the former Soviet Union to introduce single pool and output-based payments [3]. Recently, it has also made first visible changes in its budgeting process, gradually shifting from input controls to accountability for results in the health sector as part of the broader public finance reforms. Specifically, programme budgets with performance indicators have been introduced in the health sector budget. While budget laws continue to use administrative and economic classifications to regulate appropriation and execution, these are applied at a higher level (i.e. avoiding detailed controls) and are better aligned with provider payment methods. In addition, previous rigid post appropriation controls have been loosened.

However, the reform process has not been easy. For several years budgeting reforms were stuck in a pilot stage and remained a paper exercise done for development partners more than internal stakeholders. As a result, the health sector struggled for a number of years with rigid input-based controls which dampened the effect of new output-based provider payment methods. Furthermore, strategic purchasing has been hampered with budgets defined too low at the provider level. Reallocations among providers reflecting health needs or their productivity were time-consuming and demanded prior approval of the finance authority. The case of Kyrgyzstan demonstrates most clearly the links between health financing and budgeting reforms and the need to align these in order to make progress for universal health coverage.

This study is part of a broader WHO programme of work on budgeting for health, which includes identifying good country practices and lessons on designing and implementing budgetary programmes in the health sector. The main goals are: (i) to provide an in-depth assessment of the current health budget structure, including the treatment of immunization in the budget, (ii) analyze the effectiveness of the transition towards programme-budgeting and its implications for the health sector, and (iii) to provide recommendations for adjustments in budget structures in health.

The study is based on a document review combined with key informant interviews conducted in July 2018. It also draws significantly on experience and knowledge of the authors who played active role in many of the reforms described in the report. The report is based on the data collected between July 2018 – March 2019 with some updates made in August – September 2019.

The initial results are to be shared and discussed with the Ministry of Health and the Mandatory Health Insurance Fund as well as Ministry of Finance in October 2019. The findings of the report will feed into the ongoing health financing policy dialogue, including the issue of overall public financing for health and addressing service delivery challenges at PHC level.

The main objective of this study is to analyse the budget programme structure in health in Kyrgyzstan. It also examines the links of budgeting and provider payment reforms in

health. With a particular focus on programme budget, the study analyses the reform process and draws lessons learnt for other countries implementing health financing and budgeting reforms.

Section II of the report begins with description of the key aspects of the health financing system in Kyrgyzstan. It describes the main stages of the reform, implementation of new provider payment methods and associated challenges, and legal status of the purchaser and providers. Section III examines the key aspects of the current budget structure, following the main stages of the budgeting process. In Section IV, the paper takes a closer look at programme budgeting in health including the process of transition, programme design and content, performance measures and alignment of programmes and their indicators with the national health priorities. Section V examines the impact of budget reforms on the health sector. It highlights what has worked and the remaining misalignments with strategic purchasing, particularly output-based provider payment methods. Finally, the paper concludes by providing key policy recommendations on changes to the current budget structure to support Kyrgyzstan progress towards universal health coverage.

2. HEALTH FINANCING SYSTEM REFORMS

2.1. MAIN ELEMENTS OF THE REFORM

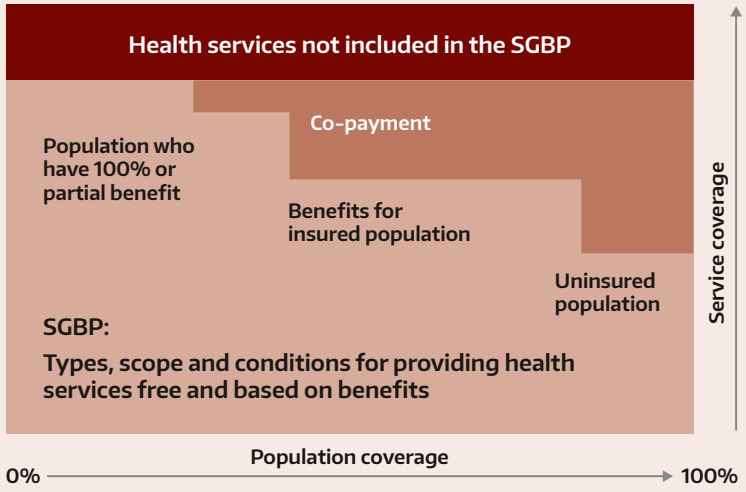
Kyrgyzstan inherited from the Soviet Union a public delivery system of health facilities under the Ministry of Health (MOH) and regional (oblast) administrations, which was financed from the general revenues based on line-item budgets for inputs (e.g. wages, drugs, medical supplies). Like other post-Soviet countries, Kyrgyzstan also inherited a system of very detailed input planning and control for healthcare providers based on norms. These were also used for budget formulation.

In 1997, Kyrgyzstan established a new purchasing agency called Mandatory Health Insurance Fund (MHIF). In its initial stage, its revenues were limited including a 2% payroll tax on employers supplemented by small amounts of transfers from the pension and unemployment funds. The insured population included employees, pensioners and those in receipt of social benefits. In total, this was approximately 30% of the population by 1999 [4]. In 2000, children aged less than 16 were added funded by a direct transfer from the central budget. This brought the insured population to about 70% in 2000 [5].

In 2001–2006, Kyrgyzstan implemented a comprehensive health financing reform with a purchaser-provider split phased in over five years and a single payer system developed. Tax revenues from the budget and MHI payroll contributions were first pooled at oblast level and managed by MHIF regional offices. In 2006 there was a shift to pooling funds at the national level, which allowed the MHIF to re-allocate funds more equitably across oblasts. In the latest phase of reform in 2016 the Government pooled much of the remaining parallel funding from the MOH budget (for most specialised services) and the Bishkek (capital) City health budget into the MHIF, though MOH continues to fund and manage some healthcare inputs and facilities directly from its own budget outside the single payer system.

Other key component of health financing reform introduced at the same time were: explicit benefits, referred to as the state-guaranteed benefit package (SGBP); official patient co-payments and exemptions for vulnerable groups (Figure 2.1.1). In conjunction with these financing reforms, the MOH implemented a major downsizing of excess capacity in the hospital sector. As a result, hospital capacity was reduced by 40%, leading to savings in utility and personnel costs and increasing the share of resources allocated to direct medical expenditure. In addition, primary care began to receive an increasing share of funding. The share of primary health care in total health financing increased from 16% in 2000 to 30% in 2004 [6]. The combined impact of these reforms improved healthcare provider efficiency and financial protection for the poor.

Figure 2.1.1: Population coverage under the SGBP



Source: [5]

2.2. SHIFT TO OUTPUT-BASED PAYMENT METHODS AND IMPLEMENTATION ISSUES

For the first three years of the Kyrgyz reforms, from 1997 to 2000, the main provider payment method was still based on inputs. At the same time, MHIF introduced new provider payment methods based on outputs, for the portion of funding received from payroll tax. In 2000, this meant that about 90% of public spending on health still came from budgetary sources allocated based on historic input patterns while 10% allocated from MHIF was based on capitation and case-based payment [4]. This funding flowed directly to facilities in parallel to the main budget and gave facilities some increased financial flexibility. In 2001, with the implementation of the "Single Payer" reform, budget revenues began to be pooled by the MHIF at the regional level where budget and payroll funds were combined resulting in the unification of provider payment methods [7].

However, while in theory provider payment methods were based on outputs, their implementation was constrained by several issues. Firstly, Soviet staffing norms did not change, therefore a large portion of the provider revenue was spent on salaries and was not something that managers of facilities could easily change. Secondly, salaries of the health workers were determined by the centralized salary grid (tariffs), which also made it difficult for managers to negotiate these at the local level, though they had flexibility to use a portion of their MHIF and copayment revenue for setting incentives for their staff. Thirdly, after appropriations are approved[l] the Ministry of Finance also set budgets at the provider level, making it difficult for the purchasing agency to shift budgets between providers without the prior

l SMETA- another feature of the soviet system is the centralised allocation process which extends budgetary control beyond the appropriations. IN KR this is based on cash plans submitted by line ministries.

Box 2.2: Pay 4 Performance/Results Based Financing in Kyrgyzstan

A World Bank-financed pilot project supported the introduction of results-based-financing (in high-income countries typically referred to as pay-for-performance) in district hospitals, paying rewards for measures of quality relevant to maternal and child health. Preliminary results from impact evaluation are positive [1]. The pilot project was implemented by a project implementation unit in the MOH, and funds flowed in parallel to the MHIF's provider payment system through a special designated account, with separate accounting for use of project funds [2]. Due in large part to the increase in PFM alignment and flexibility brought about by the new MHIF Budget Law in 2018, the MHIF has been able to take over the payment scheme after the end of the pilot and institutionalise payment arrangements within "mainstream" provider payment and public financial management systems for hospitals. MHIF is now able to allocate funds in its budget to scale up the project to cover regional hospitals and extend coverage of primary health care facilities, drawing on lessons from pilots supported by development partners.

approval of MoF. Fourthly, provider budgets were still formulated and approved based on inputs. Fifthly, budget execution also did not change and was based on rigid central ex-ante controls regarding shifts between input lines. Lastly, there were also strict regulations on spending by source of financing at the provider level. There were four main sources of revenue: central/republican budget, mandatory health insurance contributions, copayments and special means.[II] Each of them was allocated by input lines with any shifts among those input lines and between sources requiring ex-ante approval. In certain cases, transfer requests were rejected.

2.3. LEGAL STATUS OF THE PURCHASING AGENCY

MHIF is a legally independent public administrative agency subordinated to the Government. Formerly, it was a semi-independent agency sub-ordinated to the MOH. The MHIF's chief executive officer (CEO) is appointed by the Prime Minister. The Vice Prime Minister (VPM) for Social Affairs is in practice the responsible Cabinet member for the MHIF and chairs the Supervisory Board (SB) for the MHIF, which has Government-approved membership and terms of reference to coordinate, monitor and advise the MHIF and approve matters which in law are within the authority of the MHIF's management. However, the SB is not recognized in legislation and therefore does not have clear legal authority in its own right, nor do SB members have clear accountability or any liability for carrying out their oversight of the MHIF effectively. A recent WHO assessment found the SB is very weak and not able to play the usual governance roles of providing strategic direction and holding the MHIF accountable for results [9].

II Special means are revenues from additional services which can be retained by the ministry, i.e. not covered by the State Guaranteed Benefits Package or other commercial activities, for example, rental of space to a pharmacy. 8. Жогорку Кенеш (National Parliament), *Закон КР Об охране здоровья граждан в Кыргызской Республике (The Law on health protection of the citizens of the Kyrgyz Republic)*, in *N 6.* 2004, Ministry of Health of the Kyrgyz Republic: Bishkek, Kyrgyzstan.

Table 2.3.1: Financial authority and autonomy of the MHIF	
Issue	**Mandatory Health Insurance Fund in Kyrgyzstan**
Payroll Tax rate/ budget contribution	Parliament adopts (MOF sets budget ceiling based on actual historic spending).
Reserves	None
Allocation of MHI budget to service programmes	Parliament approves allocation to administrative/service categories, with single line of economic classification. Until 2006 Parliament approved budget by economic classification.
Allocation & execution of provider payments according to line-items (economic classification)	Provider budgets by economic classification line items are approved and executed by MHIF through the single Treasury system. MHIF is obliged to cover protected input costs – wages, drugs, food even if this amount exceeds payment for performed services. Until 2018, MOF local Treasury offices also approved provider budget allocation & execution.
Retention or carry-forward of savings	The 2019 Budget Law on Mandatory Health Insurance Budget, Article 11 states that the MHIF as well as service providers under MHIF will be able to carry forward unspent funds from all revenue sources [10].

Prior to 2018, MHIF in Kyrgyzstan has had very little financial autonomy, but a new law passed last year has increased its financial autonomy to formulate, negotiate and execute its budget. Specifically, MHIF received the authority to formulate and negotiate its budget directly with the MOF and independently of the MOH. Also, with this law, post appropriation controls of the MHIF budget imposed earlier by the MOF, (described further in Section 3 of this paper), were removed. Moreover, the authority for regulating and controlling budget execution by providers was delegated to the MHIF. However, the MHIF still does not hold financial reserves[III] and its SB does not have primary authority to approve MHIF budget and financial policies – the MOH and MOF remain the primary authorities, even if the SB is consulted and invited to endorse proposals for Ministry decisions. Financial authority and autonomy of the MHIF are summarized in Table 2.3.1.

2.4. STATUS OF PROVIDERS AND HEALTH WORKERS

The overwhelming majority of healthcare providers in Kyrgyzstan are public entities under a law that in theory permits financial and managerial autonomy. According to the Law on Health Care Organizations [8], public entities are owned by local government units or the central government but are entitled to financial and managerial autonomy within the limits of the legal framework and based on the contracts with the MHIF. Formally, this Law appears to give public providers autonomy. For example, according to Article 34, public providers contracted by the MHIF are able to plan, approve, and make changes in their own budgets. They also have a right to change the staffing structure and number of staff, based on the expected revenues. However, at the

III Reserves are a feature of many public sector single purchasers/insurers. Usually the HIF law regulates cumulation of reserves from unspent funds in lower-demand/lower cost years which may be drawn down in higher demand/higher cost within limits defined in the law and subject to approvals defined in the law. This is reconcilable in practice with annual budgetary control – spending of reserves within a year is subject to approval by MOF and governance body and reflected in adjustments to annual appropriations in-year if necessary. The Estonian Health Insurance Fund is an example.

same time, (Article 38) providers must follow budget law and regulations and procedures of the State Treasury, and are also subject to labour law and health sector regulation under other legal acts. Managers are appointed and can be removed from their office by the local government administrations with the approval of the Ministry of Health.

In reality, the cumulative effect of Treasury and other regulation has meant that public providers have limited financial or managerial autonomy. Until 2018, they functioned under the same budget rules and processes as other operational budget entities in spite of the fact that their budgets were not appropriated in the national budget. Although the MHIF's central budget subsidy which was appropriated provided the resources for the public providers that were included in the MHIF's "single payer system", public providers continued to execute their budgets through the unified Treasury management system and hold all their cash in the Treasury account system. Treasury regulations and procedures involved MOF approval of provider budgets by detailed economic classification for each source of finance, within the global resource envelope determined by MHIF's output-oriented contract. Input regulations (staff norms, regulated ratios for spending on various inputs) were applied at this budget planning stage. Treasury procedures then exercised inflexible prior controls on provider spending by detailed economic classification and source of funds per month. These input regulations and inflexible budgets then became the basis for audit by the Chamber of Accounts. All this made it extremely difficult for providers to reallocate funds across line items to provide the right input mix for treating patients across the year. While it is appropriate for public providers to account ex post for funds and make financial reports to the MOF and MHIF under the same chart of accounts and processes as other budget entities and to be subject to audit by the Chamber of Accounts – the state audit authority – the requirement to account and report by separate sources of funds is not meaningful. From 2018, under new legislation, the MOF no longer plays a role in approving each providers' budget plans and giving prior approval to expenses and payments. These roles have been delegated to the MHIF.

Health workers and other employees of public facilities are public sector employees, with associated protection, privileges and benefits. According to Article 85, health care workers are entitled to the guaranteed level of income where the minimum wage should not be lower than the official average wage for Kyrgyzstan [8]). There are also specific guaranteed increases for years of service and professional achievements. However, health workers are also allowed to receive pay-for-performance: in fact, even before the World Bank Results-Based Financing in Health Project, facilities were allowed to provide salary top-ups to their staff linked to their performance or productivity, referred to as the "coefficient of labor contribution".

3. BUDGET STRUCTURE TODAY

3.1. BUDGET FORMULATION AND APPROVAL

The annual budget process is based on a three-year medium expenditure framework. Ceilings set by the Ministry of Finance in a three-year rolling budget are formulated based on the following elements:

- overall macroeconomic indicators and hence, expected general government revenues
- historic trends (last year's budget basically)
- funding required for new government policies, which are often formulated as input-related measures such as "increase the minimum salary of health workers and teachers" (although they can be also formulated as outputs or objectives such as "ensure free access to hospital care for all children under 5").

With increased independence of the MHIF and its new status (see above), there is no single sector ceiling. Instead, MHIF and MOH each receive their own budget ceilings. They also negotiate their budgets separately and at times, appear to compete. As it is described further below, this makes it difficult for anyone to see the overall picture of health sector financing.

Budget formulation is largely a top-down exercise and does not account for the expected growth in the cost of health services, including the SGBP. It does not use any methodology for projecting costs of the SGBP to meet rising need/demand due to population growth and ageing, nor is there any methodology or strategy to close the current financing gap for the package (met by patient payments or rationing of care for SGBP services). As well, there is no evidence-based methodology for determining the share of the budget allocated to SGBP. Nor is there use of evidence to review priorities in allocation of budget resources across MHIF programme categories (e.g. the balance of allocation to PHC versus specialised services or contracts with private providers), to align allocation with national policies and strategy priorities.

Until 2019, if facilities increased productivity and reduced staff (FTE posts, not actual physical persons), the whole health sector budget suffered a cut. This led to deep mistrust between the sector and the MOF and associated resistance to any initiative to close facilities and cut beds or staff. The issue is partly addressed in Article 6 of the 2019 Republican Budget Law, which states that it is allowed to decrease funding for protected items (e.g. salaries) where staffing norms have changed due to new regulations, except for the programme budget pilot ministries and agencies, which include health [11].

The MHIF sets its own ceilings to facilities in the "single payer system" based on the population enrolled and the number of treated cases in previous year. Facilities are then asked to prepare their budgets by inputs, based on detailed economic classification ("smeta rashodov") and submit this to the

territorial office of MHIF for approval. This "smeta" is then aggregated in Republican MHIF, which then prepares the draft budget to be submitted to MOF. There is some room for negotiation at this stage if the bottom-up process results in expenditures larger than the ceiling provided for the MHIF.

The state consolidated budget consists of the republican (central), local, social fund and the mandatory health insurance fund budgets. However, the latter two are approved by Parliament separately (Figure 3.1). Health expenditures are financed through the Republican (central) budget and the MHIF budget. Until 2018, the MHIF budget was divided into two: the majority of expenditures, financed from general tax revenues, were approved as part of the Republican (central) budget; while expenditures financed by payroll contributions for health were approved as part of the Social Fund Budget Law. Since 2018, MHIF consolidated budget from both sources is approved separately under its own MHIF Budget Law with transfers to the MHIF from general tax revenues appearing in the republican (central) budget under the Ministry of Finance.

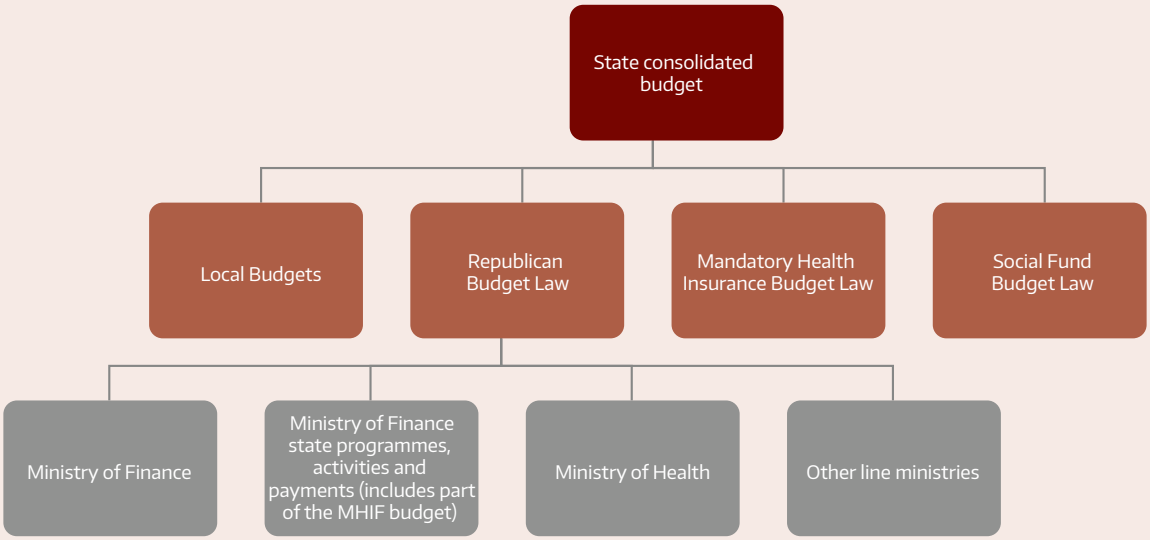
In 2019, the programme classification is still used mainly for information – as an alternative presentation of the budget, although according to the general law on budgets (the Budget CodeIV) it should become the main basis for appropriations. However, the full implementation of the Budget Code is being phased in gradually. **The Ministry of Health is a pilot Ministry for implementation.** According to Article 4 of the Annual Budget Law 2019, expenditures under the Republican budget, including MOH, are appropriated based on three main classifications: functional (Annex 4), administrative (Annex 5), and economic (Annex 6). (see Tables 3.1 A-D in Annex 1). Importantly, with the change in the status of the MHIF and the introduction of a separate annual MHIF Budget Law from 2018 onwards MHIF effectively has a single line appropriation for its entire budget. However, functional classification, 707, which typically should reflect the entire health function, only includes the MOH budget. MHIF spending which in 2018 constituted 86% of the recurrent budget expenditures on health is no longer reflected in the health function but instead under the function for General public services, more specifically code 7018, for Transfers of a general character between different levels of government, reflecting a certain misunderstanding on the part of the MOF of how to use functional classification.

The MHIF budget is approved in a separate budget law; however, state budget transfers which constitute the majority of the MHIF's revenues are part of the main annual budget law. The part of the MHIF revenues which come from state budget transfers (i.e. financed from general taxes, not copayments or providers own revenues or mandatory health insurance (MHI) contributions) is now reflected under the Ministry of Finance's budget for state programmes, activities and payments (see Figure 3.1.1), which can be confusing and makes it difficult to have an overview of the sector budget and its priorities as a whole.

The full budget for MHIF (i.e. including own revenues and health insurance contributions and the MOF transfer) is approved in a separate law, which presents its budget using all four main

IV The Budget Code sets out the permanent legal provisions on budgets. There are also annual budget laws, enacting the Republican Budget, the MHIF Budget and the Social Fund Budget, for each year.

Figure 3.1.1: Overview of the state consolidated budget



classifications: functional, administrative, economic, and programme. However, only the MHIF central and regional administration budgets are presented using a detailed economic classification. The budget for service delivery purchased by the MHIF is presented under the single line in the economic classification for goods and services (code 221): 36141 MHIF – Single Purchaser (health care organizations) line under the administrative classification contains all expenditures under the code 221.

3.2. BUDGET EXECUTION

Budget execution follows the appropriation structure using the treasury single account; and shifts in budgetary lines approved in the annual budget law require prior approval of the MoF and eventual reflection in the revised version of the law. Starting from 2019, spending units, including health, are permitted to vire up to +/-5% between line items within each programme classification without prior MOF approval [12]. However, while the Budget Code allows this type of virement, it is not yet practiced because underlying regulations and procedures for approval have not been revised accordingly.

There is less fragmentation with the new MHI Budget Law. According to it, on the expenditure side, all four sources of funds (Republican Budget, MHI, copayments and provider own revenues referred to as special means) are managed and accounted for as a single pool of funds. This replaced a very rigid system that required separate budgeting, reporting and execution for each

of the four sources and by line item. MHIF is proceeding cautiously towards this goal and still requiring facilities to report on and execute their budgets in three categories: republican budget and MHI contributions combined, copayments and special means. While the regulations restricting the use of each source to specific line items were repealed in 2017, some facilities still follow these as a cautious approach. As well, some regulatory restrictions on input mix remain. For example, the decree on health worker wages states that only MHI contribution funds and special means (providers' own revenues, e.g. for privately financed services) can be used for salary bonuses [13]. This is yet to be updated to be in line with the new way of managing the four revenue sources as a single budget.

Budget execution starts with development, consolidation and approval of cash plans. Health service providers contracted by the MHIF submit their cash plans to MHIF for review, approval and consolidation. As described above, the four sources of facility revenue are now managed together. Therefore, each facility now prepares one single cash plan and has a single account within the Single Treasury System (at the local treasury office) where funds from all four sources are co-mingled. Each month the MHIF transfers 1/12 of the combined Republican Budget and MHI allocation to the respective treasury office account. Special Means and Copayment Revenues for providers are also deposited in the same account of the Treasury district offices. From here, providers access these funds and can spend their aggregate cash ceiling for the month on any line item from the cash balance of all four sources as they need.

Previously, each source of revenue and each line item were divided by 12 and facilities could only spend up to that limit on each line item by each source in each month. Now, they have more flexible disbursements during the year. This is a significant improvement in cash pooling compared to the previous arrangements when virement across line items was difficult and slow, while virement across sources within the year was not allowed. Now they need to notify MHIF for virements across lines, but no longer require prior approval from MOF. However, based on field visits and discussions, it seems that some providers still believe that when they get to the end of the year, they should be in compliance with their initial budget for each of the four sources and line items per source. This may reflect caution on the part of facilities because 2018 was the first year of implementation of the new MHIF law.

The Integrated Financial Management Information System[V] used for budget execution is an electronic system accessed both by the spending agency, e.g. MOH, and MOF. Between 2006 and 2018, although appropriations in health was based on high level administrative and economic categories and a four-digit functional classification (e.g. medical products, appliances, and equipment; outpatient services; hospital services), strict controls were introduced at the post appropriation stage (Smeta stage) (Figure 3.2.1 A). Given the new status of the MHIF and the fact that its budget is now adopted through a separate law, MHIF has been given significant freedom in its budget execution process. Since 2019, MHIF and health providers use an IFMIS module specially designed for the health sector: essentially, it allows providers to make payments without detailed prior controls of the Treasury.

V Locally developed software (LDSW) developed by a local provider who supplies services for the government to maintain the systems.

Payments are still coded and processed at eight-digit line-item level; however, the prior approval is now performed by the MHIF.

MOF no longer exercises prior control over provider-level budget execution at the line-item level during the budget execution process. The new law delegates full responsibility for this to the MHIF. The MHIF sets a single budget ceiling or control total for each provider according to the output-based payment method in its contracts. The new law also allows providers to retain unspent balances at year end. However, because of caution due to perceived weakness in financial management and control at the provider level, along with concerns regarding adverse opinions from external auditors, in 2018 and 2019 MHIF required providers to continue to prepare budget plans by detailed input lines, which are now submitted for review and approval by the MHIF. In effect, the MHIF now has the authority to review, approve and process the budget requests of contracted providers under the Single Payer System (Figure 3.2.1 B) – the role previously fulfilled by the Treasury. At the same time Healthcare providers continue to use the single Treasury management system for all payments.

Figure 3.2.1: From appropriations to execution: the flow of funds to providers under the Single Payer system

Figure 3.2.1 A: Before 2018

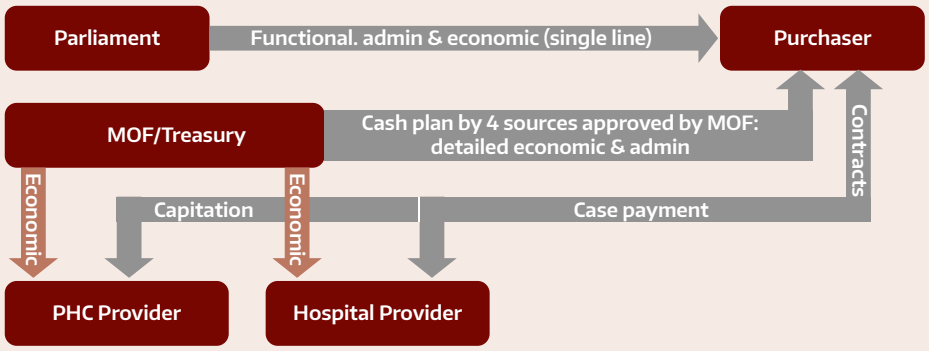
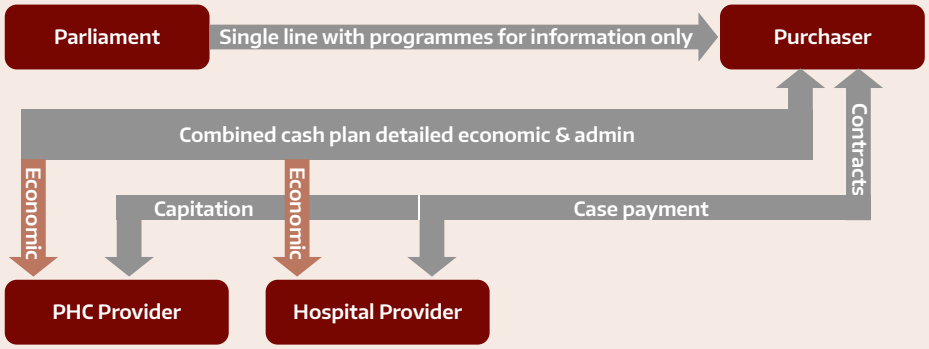


Figure 3.2.1 B: After 2018



3.3. MONITORING AND REPORTING

MOH and MHIF report quarterly to the MOF by program, sub-program, administrative category and economic classification. MHIF is obliged to submit separate reports to the MOF for expenditure financed by the Republican Budget and MHI payroll contributions. MHIF aggregates the financial reports of the providers in the single payer system and submits quarterly aggregated reports to the MOF. The MHIF provides reports disaggregated by the four sources of provider revenue, and also disaggregated by line item and continues to do so even after the 2018 reform. MHIF also provides the MOF financial reports on individual providers on a quarterly basis and makes this information available to the MOH on request. MOH requests are usually related to particular problems with a provider. MOF and MOH do not routinely review individual provider financial reports.

It is a noteworthy feature of the Kyrgyz health system that although the MOH "owns" almost all public health facilities, it plays no role in routine or regular monitoring of their financial performance. The MHIF alone has the systems, data and capacity (though very limited) to monitor and review provider financial performance. MHIF does financial monitoring (through its finance directorate) alongside its role as a purchaser in monitoring contracts (through its contracting division). A number of public providers have financial deficits. The MHIF has de facto responsibility for dealing with financially distressed providers, through obligations to finance protected line items (salaries, drugs, food) even if regular provider payment revenues are insufficient to cover these costs. The MHIF has on occasion negotiated with providers to reduce costs (e.g. reduce excessive staff posts). The MOH becomes involved on an adhoc basis in crisis situations or where a provider's financial problems attract political attention. The MOH also has responsibility for planning the provider network and for setting and reviewing input-related norms and granting approvals related to these norms (e.g. to vary staff posts).

Providers are subject to inspection and audit by a number of external bodies in addition to the MHIF. On financial matters, the Chamber of Accounts is responsible for audit as the supreme state audit body. Other agencies – e.g. the labor inspectorate – have roles that can affect provider budget planning and resource use.

In addition, commencing in 2019, MOH, as one of two pilot line ministries, must also report on a quarterly basis to the MOF on performance indicators at sub-programme level. However, budget allocation is not linked to performance; and it is unclear how MOF will use these indicators. Also, at this stage performance indicators are not integrated into IFMIS and are collected separately and in many cases manually through a paper-based system. In addition, there are issues related to the quality of these measures, as discussed in the next section.

4. PROGRAMME BUDGETING IN HEALTH

4.1. TRANSITION PROCESS

The adoption of the new law on the Budget Code in 2016 [12] integrated programme budgeting into the regular budget cycle. Prior to the adoption of the new Budget Code, the use of a programme classification in the budget presentation was subject to annual Government decrees and did not have a strong legal basis. Commencing in 2019, spending units in the two pilot ministries must now report on programme performance indicators quarterly. Virements of +/-5% are now also allowed within programmes but not across programmes. However, despite the legal requirement,[VI] in practice, the budget is still based on the traditional approach combining administrative and economic classifications. In practice this means that the MOH continues to conform its spending to programme, administrative and economic classifications for its budget.

The transition to programme budgeting in health began in 2000 as part of the efforts to introduce medium-term expenditure framework (MTEF) strongly pushed by development partners but with limited local stakeholder buy-in. Four pilot line ministries, including health, were asked to prepare medium-term strategies with description of their objectives, activities and expected results (Figure 4.1.1). However, there was no direct link between these descriptions and budgets, which were still presented only using functional, administrative and economic classifications. Between 1997 and 2008, several projects working towards implementation of MTEF were supported by the UK DFID, World Bank and USAID. As part of these projects, a series of training programmes were conducted for line ministries. In 2008, DFID experts developed guidelines on preparation of the MTEF and programme-based budgets. However, these guidelines had limited use by the MOF or line ministries. In general, between 1997 and 2008, efforts to introduce programme budgeting in Kyrgyzstan were driven by development partners and had little support or buy-in from the local stakeholders. Thus, when projects were completed, activities supported by these projects were largely shelved. Documents developed by these projects were "piled up" with limited use. Only the pilot ministry budgets, including health, were presented using programmes as part of the MTEF.

New stage of programme-budget implementation started in 2011 with MOF starting to own and leading the budget reform process. This new energy around and motivation for public finance reform was driven by the continued growth in public spending without visible improvements in public services, including health, and the general population discontent with these services. In addition, in 2009, Public Expenditure and Financial Accountability assessment was implemented in the country. Based on the results of this assessment, the Government adopted public finance reform

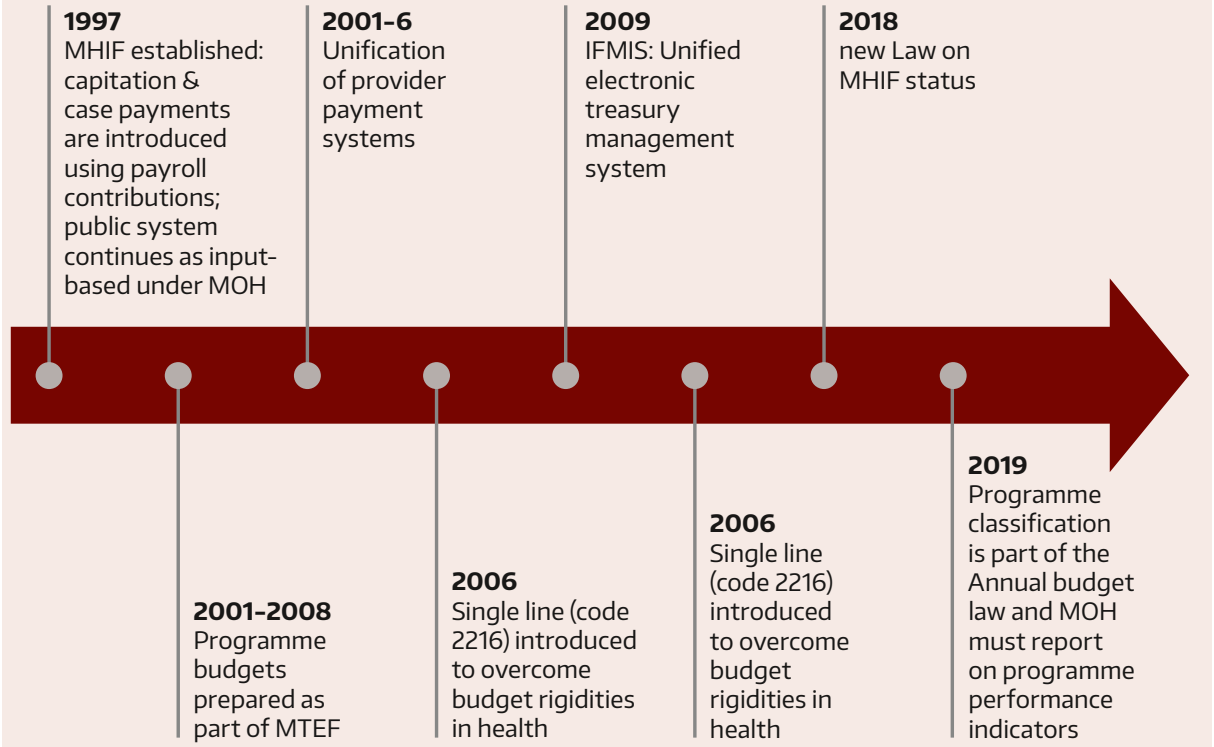
VI As noted earlier, according to the new Budget Code programme classification should be the main basis for appropriation and execution.

plan for 2009 – 2013. One of strategic priorities in this reform plan was transition to results-oriented budgeting [14]. With support from the multi-donor trust fund on strengthening capacity in public finance, MOF redesigned the budget circular providing guidance on programme-based budget preparation. Four pilot ministries, including health, were selected for implementation of programme-based budgets. Between 2011 and 2016, the redesigned budget circular and the list of pilot ministries were approved on an annual basis through Ministry of Finance orders and Government decrees. Therefore, it seemed that programme-budgeting did not have strong legal foundation and it was unclear if it would continue beyond a given year. The list of pilot ministries was expanding however, and by 2014, all ministries and agencies funded by the state budget had to present their budgets using budgetary programmes.

Similar to other countries, however, MOH and MHIF in Kyrgyzstan largely played a passive role in the transition to programme-based budgeting. Particularly in the early years of its implementation (2000 – 2010) it was perceived largely as an exercise done for the satisfaction of donors and its purpose and utility to the sector were unclear. This was understandable as health sector reforms were constrained by rigidities imposed through input-based line item budgeting and weak links between stated policy priorities (such as ensuring access to good quality health services for pregnant women and children) and the state budget. Thus, domestic health sector stakeholders did not see how programme-budgeting could help them overcome these barriers. This was partly due to a weak understanding of the benefits of programme-based budgeting among health ministry and health insurance fund technical staff responsible for budgeting and planning It also reflected that whatever theoretical benefits that this new approach was achieving in other countries (e.g. Australia, South Africa), they would not be realized in Kyrgyzstan as it would remain a paper exercise done for donors or MOF. Ministries did not have confidence that the multiple layers of input regulation, control and inspection would be reformed in the near future, and were cautious about reducing such control in the case of health facilities with documented weakness in financial management and control.

At the same time, given the constraints posed by input-based budgeting with facility-level caps on effective implementation of strategic purchasing, the MHIF was actively pushing for relaxing ex-ante controls of inputs and allowing the purchaser to reallocate budgets across providers. One way of achieving this, was the introduction of the single line within the economic classification, covering all expenditures by the MHIF related to the implementation of the state guaranteed benefits package. Thus, for some years Kyrgyzstan had a hybrid budget structure where the standard economic classification was combined with a programmatic line, encompassing almost 80% of health sector expenditures. However, since the underlying logic and system did not change, strict controls continued at the post appropriation stage, Smeta. Gradually, it became clear to the health ministry and the purchasing agency that this creative solution would not work and a more systematic change had to happen. With this understanding, health became one of the strongest supporters of the MOF-led efforts to implement programme-budgeting.

Figure 4.1.1: Timeline of purchasing and programme-budgeting reforms



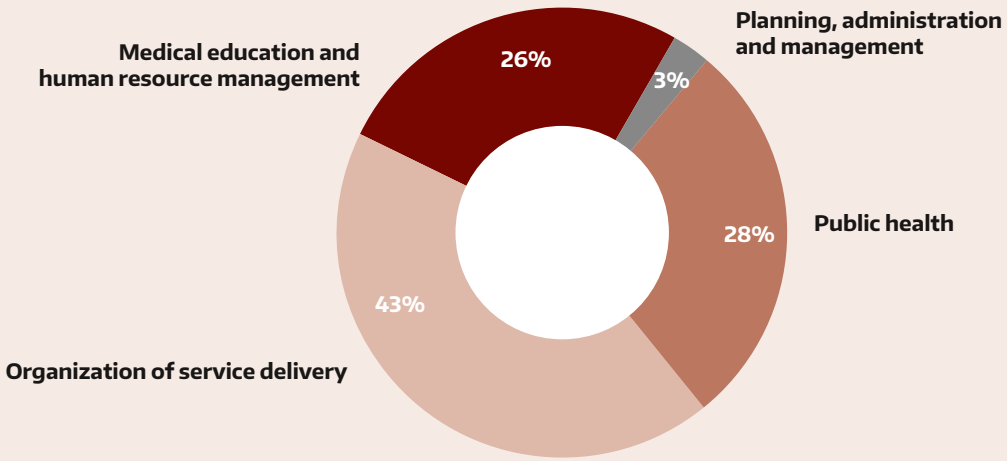
4.2. PROGRAMME DESIGN AND CONTENT

Budgetary programmes in health are of mixed quality when it comes to programme design. The programme structure consists of two levels: programmes and sub-programmes (referred to as budgetary measures in Kyrgyzstan). In the 2019 programme budget, the health sector has eight programmes (four programmes each in the MOH and MHIF budgets) and 61 budgetary measures in total.[VII] According to the Budget Code, article 85, a programme is defined as a set of budgetary measures which are implemented to achieve a common objective within a given sector [12]. Thus, in Kyrgyzstan, programmes, by definition, are not multi-sectoral. In fact, because the highest level of appropriation is by ministry or agency programmes cannot cross different ministries or agencies. Thus, although MOH and MHIF both have programmes or sub-programmes directed at the same objectives, they have separate programmes for their respective expenditures towards these objectives. While programmes largely appear to follow good practice in programme design, sub-programmes are a mix of organizational units, special disease categories, levels of care, and very narrow activities.

In line with general recommendation (see Barroy et al, forthcoming), the Ministry of Health three service deliver programmes are well balanced in terms of size (Figure

VII This excludes a programme on infrastructure investment, which covers capital expenditures financed by external assistance.

Figure 4.2.1: Relative size of budgetary programmes under Ministry of Health, 2019

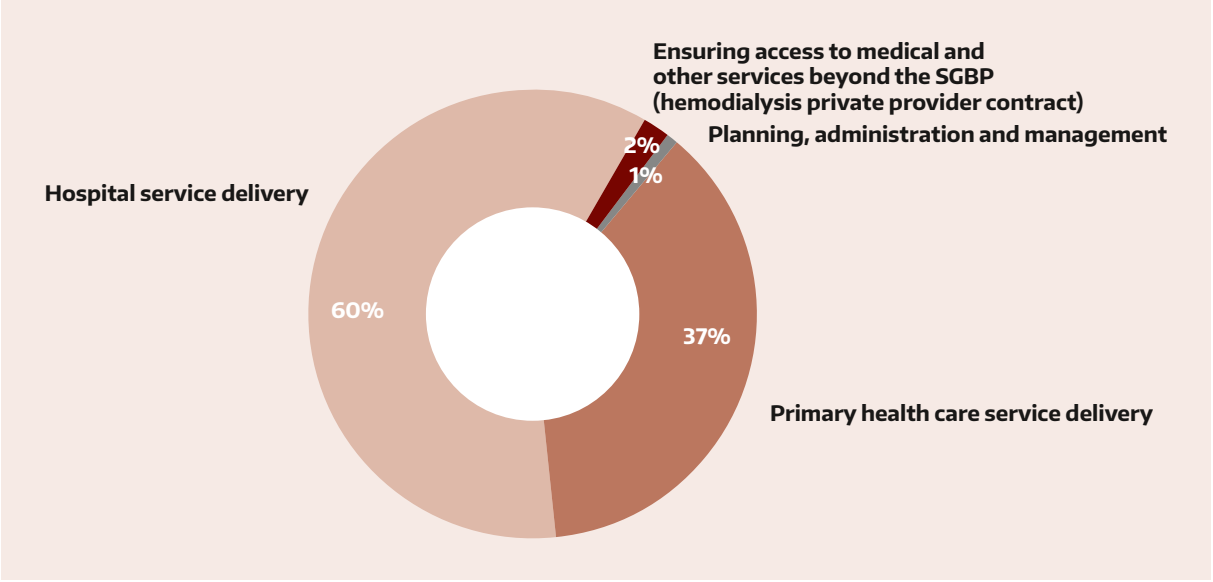


Source: [11]

4.2.1). Overall, programmes have well-articulated objectives, However, similar to other countries (e.g. Ukraine) there are issues with the budget measures/sub-programs. For example, HIV prevention, diagnosis, treatment and care is placed under the Public health programme, which typically should include population-level interventions and not individual services. Also, several budgetary measures directly correspond to different units within the Ministry (e.g. legal support, clerical work, internal audit services) while others are very narrow condition specific procurement activities (e.g. insulin provision, provision of antihemophilic drugs, provision of immunosuppressants for patients with organ transplantation, procurement of diagnostic tests for vulnerable TB patients). In other cases, programmes or budgetary measures are delineated according to the ownership of the provider: for example, provision of paid services to the population beyond the State Guaranteed Benefits Package (which controls spending on private hemodialysis provision); or according to the revenue source: for example, provision of non-medical and other services by health service providers working in the Single Payer System (which controls spending of from paid services).

MHIF also manages four programmes, two of which – PHC and hospital service delivery – make up 97% of its total consolidated budget expenditures. A third programme is for one specific service (hemodialysis) with a specific instrument (contracting with private providers) contains only one activity (Figure 4.2.2). Lastly, there is a fourth separate programme for support services as is the case with MoH, which is a recommended practice in programme design particularly for developing economies [15]. At sub-programme level, budgetary measures have a very clear logical link to the programme objective and name. However, sub-programmes vary widely in size: for

Figure 4.2.2: Relative size of budgetary programmes under the Mandatory Health Insurance Fund, 2019



Source: [10]

example, activity on ensuring access to basic medical services at PHC level under the SGBP makes up 78% of the PHC programme budget while the rest of the seven programmes, such as access to emergency care, Additional Drug Benefit Package, TB treatment at PHC level and quality improvement through performance-based financial incentives, share the remaining 22% of the budget.

The structure of the programmes has changed substantially over the years. In 2015, when budgetary programmes were for the first time presented in an annex of the annual budget law (although they were for information only and not mentioned at all in the text of the law), there were eight programme in total, three of which were managed by the MHIF [16]. The MHIF programmes were not organized by level of care as they are now (Table 4.2.1). In fact, all expenditures for primary care and hospital services under the SGBP, which constituted 68% of overall health sector budget, were under one programme. The programme on basic health insurance included cancer treatment, hematology, highly specialized eye surgery and specialty cardiology services for the insured. In addition, it included the outpatient drug benefit package. The share of this programme in health sector budget expenditures was just 4% [16].

Table 4.2.1: Budgetary programmes in health, 2015 – 2017

MHIF	Ministry of Health
☐	☐
☐ State Guaranteed Benefits Package	☐ Planning, administration and management
☐ Programme on basic health insurance (Note: it included the outpatient drug benefit package)	☐ Individual health services
☐ Planning, administration and management	☐ Programme for financing high technology and expensive services
	☐ Public health
	☐ Medical education and human resource management

Box 4.2: Immunization services

Kyrgyzstan depends heavily on external funding for financing vaccines used in routine immunization. As of 2017, the share of government expenditures in total expenditures for routine immunization was 27% [17]. Similar to other countries, Kyrgyzstan has a national immunization plan (NIP), which is a government programme that operates within the framework of overall health policy. NIP includes only routine vaccines, i.e. it does not include seasonal influenza or antiplague vaccines. It is managed by the Republic Center for Immunoprophylaxis (RCI), which has a semi-autonomous status. RCI is responsible for immunization policies and strategies as well as procurement of vaccines, monitoring and surveillance.

Expenditures related to immunization sit within the Public health budgetary programme managed by the MOH. They are reflected at sub-programme (budgetary measure) level under the title "Immunization policies". Activity expenditures under this sub-programme include:

- Expenditures for procurement of vaccines and medical supplies
- Expenditures for logistics and delivery (customs clearance, storage, transportation)
- Salaries and social contribution payments
- Expenditures for security services of the national vaccine storage
- Travel and per diem
- Administrative expenditures of the RCI (office supplies, communication, transportation etc)

Given the small share of Government financing the budget line for this sub-programme is small: in 2019 approved budget, it was 17% of total expenditures under the Public health programme or 5% of total MOH programme expenditures [11]. Over the past three year it has largely stayed the same, increasing only by 2% between 2017 and 2019 while the overall MOH expenditures for all programmes under its management increased by 13%.

Unlike in Armenia [18], there are no immunization coverage related indicators at programme level. However, at sub-programme (budgetary measure) level there are two immunization indicators:

1. Share of children under 2 years of age who received the full vaccination course
2. Percentage of vaccinated persons according to epidemiological indications for the prevention of especially dangerous and quarantine infections (from rabies, plague, tick-borne viral encephalitis)

The indicator on the share of children under 2 years of age who received the full vaccination course does not seem to be particularly sensitive and hence useful for monitoring programme success: indicator targets are formulated as "not less than 95%" for 2019 -2021. A more nuanced formulation and target setting to address issues of pockets of under-coverage may be more useful.

The process of revising programmes coincided with the development of the State programme on public health protection and health care system development "Healthy Person – Prosperous Country" for 2019-2030 (hereafter – Health strategy 2030) [19]. Health strategy 2030 provided an opportunity to link the program objectives and indicators with the budget allocation exercise. In fact, the decision to review the 2015 – 2017 programmes was prompted by the development of the new strategy as well as further changes in the roles and responsibilities of the MOH and MHIF. The current programmes and sub-programmes were designed by the Ministry of Health and MHIF in close consultation with MOF and in consultation with key development partners in health. Originally, MOF made the suggestion on programmes, which they identified based on the new national health strategy. While it was a welcome move to ensure that programmes reflected the national health strategy, the approach sought to match each strategy priorities and planned activities one-to-one with the budgetary programmes and measures resulting in a budget that was too detailed and fragmented. MOH and MHIF wanted to ensure that the new programme classification did not lead to even tighter control by MOF. Development took place over four months and there were many iterations and discussions before agreement was reached on the final design. Compromises had to be made between the theoretically ideal budgetary programmes, and the need to reflect the current organizational structure of the Ministry and the MHIF, as well as a realistic approach to costing and management of the programmes.

Programme costs were developed using a top-down approach and reflecting historical budgets of the spending units at various levels included in each programme. To simplify the process each spending unit or cost center was mapped to a programme in the MOH budget. In the case of the MHIF budget, each programme corresponds to one type of provider payment method for one functional type of provider (capitation for primary care providers, and case payment for hospital providers). Contracts with private providers (at this stage only for hemodialysis) were assigned to a separate programme. This means that one service provider – even in cases of large multi-profile hospitals –is assigned to one programme, which keeps the process simple. Only a small number of health centres that provide both PHC and hospital services in remote areas are funded from two programmes. MHIF's own administrative costs are assigned to a fourth programme.

4.3. PERFORMANCE MEASURES

The 2019 budget submission must contain performance indicators and milestones for programmes and budgetary measures for all line ministries. Thus, the performance measurement framework now forms an integral part of programme budgeting in Kyrgyzstan, linking budgetary programmes and the National Health Strategy. According to the budget law, Article 18, MOH must report on these performance indicators to the MOF and the Office of the Prime Minister on a quarterly basis, although budget allocations are not linked to the achievement of targets at this stage. As described above, revision of programmes in 2018 took place at the same time as the development of the National Health Strategy and many of the stakeholders were also involved in design of the performance indicators.

Unlike many other LMICs, there is a limited number of programme level performance indicators, avoiding overload of information and an excessive reporting burden. There are fourteen programme-level indicators in total, with an average of approximately three to four indicators per programme. In comparison, in Ghana there 42 indicators on average per programme (cite Ghana case study). In addition, there are ninety budget measure indicators (averaging 1.5 per sub-programme), which are also reported to the MOF and the Office of the Prime Minister.

In general, the programme indicators are reasonably well formulated, although some improvements are warranted (Table 4.3.1). For example, the PHC programme indicators on patient satisfaction and utilization of primary care are valid indicators and are well formulated. The indicator on the number of outpatient departments at PHC level which replaced in-patient care for the budgetary programme on service delivery is also a good indicator, reflecting the programme objective. However, prioritization of PHC expenditures is not an appropriate programme indicator as it relates to control at the budget appropriation stage. For hospital service delivery, given its stated objective, it could be more appropriate to have a thirty-day readmission rate or prevalence of hospital-acquired infections rather than hospitalization rate as an indicator. Public health programme has an indicator, which tries to measure the degree of collaboration between centers for disease prevention and state sanitary and epidemiological surveillance and local government units (LGUs). However, the main priority of this programme is to ensure a well-functioning surveillance system with properly equipped and staffed laboratories. While intersectoral collaboration and community participation are important elements of the public health programme, the content of public health programme goes well beyond collaboration with LGUs. The indicator on the proportion of centers which reached agreement with LGUs

Table 4.3.1: Performance indicators for selected programmes in health, 2019

Programme name and objective	Indicators
Primary health care service delivery Objective: Ensure early detection and diagnosis and increased effectiveness of treatment and quality at PHC level	1. Prioritization of PHC spending measured as a share of PHC expenditures in total public spending on health 2. Utilization of primary care measured as number of visits to family group practice per person per year 3. Share of PHC providers who introduced Electronic Queue Management System 4. Patient satisfaction rate
Hospital service delivery Objective: Increase quality and effectiveness of guaranteed services at hospital level	1. Hospitalization rate per 100 people 2. Patient satisfaction rate 3. Share of public spending on food and medicines at hospital level
Public health Objective: Develop sustainable public health services based on integrated approach to programmes on disease prevention and health promotion, intersectoral cooperation and active participation of communities	1. Share of district and city centers for disease prevention and state sanitary and epidemiological surveillance, which reached agreement with local government units on inclusion of activities aimed at prevention of communicable and non-communicable diseases in their work plans
Organization of service delivery Objective: Increase quality of care for all population groups	1. Number of outpatient departments at PHC level which replaced in-patient care

Source: [11]

is more appropriate as a budgetary measure and not a programme indicator.

The performance dialogue in Kyrgyzstan emphasizes accountability and control with a limited focus on performance improvement, e.g. for diagnosing performance gaps and developing solutions. Due to the Soviet legacy, which is similar in many other LMICs [20], performance measurement is still seen as a way of controlling managers and imposing penalties on those who fail to achieve the set targets, rather than positively encouraging performance. Therefore, even during the preparation of the programme budget for 2019 there was resistance and fear within MOH and MHIF to include more outcome-oriented or ambitious targets even where they are priorities in the National Health Strategy, because it was felt that if indicators were made part of the official budget submission and had to be reported, they would inevitably be used for administrative sanctions. Some of the programme indicators proposed by the MOF (e.g. under five mortality rate) were rejected by both MOH and MHIF partly because of this. However, it is worth noting here that mortality indicators such as under five mortality rate or maternal mortality ratio (which are important outcome measures for a long-term health strategy) are not appropriate as programme level indicators.

4.4. ALIGNMENT OF NATIONAL SECTOR STRATEGY AND PRIORITIES AND PROGRAMMES FOR 2019

The current programme structure reflects the emphasis on PHC and public health services in the new strategy. The main goal for Kyrgyzstan as stated in the new strategy is to ensure that by 2030 every citizen and community are involved in their own health and are leading healthy lifestyles. To support this overarching goal, the health system must provide integrated care at all stages of life built on strong primary care and public health services with the emphasis on prevention and early intervention. Hospital services will need to be further rationalized and modernized to ensure good quality care as described in the strategy [19]. The new programme structure allows stakeholders to easily trace budget allocation and execution to these stated priorities.

The Performance measurement framework is also well aligned with the national health strategy. As described in section 4.2, the current programme structure and performance measures are closely linked to the Health strategy 2030. In fact, many of the programme and sub-programme indicators are the same as those included in the 2030 strategy. Thus unlike some other countries (e.g. Armenia), in Kyrgyzstan, the budgetary programmes and their performance measures are well aligned with the key health policy document and its monitoring framework.

4.5. ORGANIZATIONAL STRUCTURE AND ROLE OF PROGRAMME MANAGERS

The highest level of appropriation in Kyrgyzstan is the main spending unit (e.g. Ministry of Health) and therefore, programmes do not cross different agencies. Moreover, within Ministry of Health programmes largely correspond to the existing organizational structure. Three main budgetary programmes managed by the Ministry correspond to three main departments – Department of Human Resource Management, Department of Service Delivery Organization and Drug Policy, and Department of Public Health. Programmes managed by the MHIF are more complex: they follow levels of care which correspond to different types of provider payment methods and map to the functional classification, with its administration budget and related expenditures assigned (rightfully) to one overall support programme.

The concept of programme management is not yet widely understood in Kyrgyzstan and the role of programme managers is not yet properly defined. There are no specific departments or units responsible for specific budgetary programmes. Policy departments or technical managers (e.g. Department of Service Delivery and Drug Policies) have limited involvement in design and management of budgetary programmes. Similar to Armenia [18], it appears that programme budgeting in Kyrgyzstan is still largely viewed as the responsibility of finance and budget planning departments.

5. IMPACT OF BUDGET REFORMS ON THE HEALTH SECTOR: WHAT HAS WORKED AND WHAT ARE THE REMAINING CHALLENGES?

Input-based budgeting was one of the key factors in incomplete process of downsizing large hospital infrastructure. Using its new provider payment methods to set budget ceilings for providers, the MHIF (aided by parallel service delivery optimization) succeeded in allocating a larger share of MHIF's budget to PHC and allocating it more equitably in relation to population needs. However, allocation of the hospital budget based on cases produced did not achieve an equitable and efficient reallocation, because of a combination of failure of political will to downsize excessive hospital capacity in the largest cities, combined with budget regulations that required the MHIF to fund "protected line items" (salaries, medicines and food, with salaries accounting for more than two-thirds of these expenditures), even where hospitals did not treat enough cases to attract this level of payment.

Also, the provider payment reforms did not create the expected incentives for provider managers to optimize their input mix to improve efficiency over time because MOF's methods for formulating the MHIF budget ceiling created systemic disincentives. The MOF used to cut the MHIF budget ceiling in the budget formulation process if health facility bed numbers or staff numbers had been reduced in the previous year. Creative ad hoc solution was negotiated with the MOF to align the budget's economic classification with the MHIF's output- based payment through creation of the special single line budget code for payments to providers, disaggregated by type of service, although the unreformed budget classification system was based on inputs (economic classification), with detailed line items. However, the creative solution of the single line (which was essentially one programme line) in an otherwise traditional budget structure did not resolve the issue of disincentives to health service providers.

While some countries addressed this type of misalignment of health financing and PFM by autonomizing public healthcare providers, giving them greater financial flexibility and moving them outside the Treasury management system, Kyrgyzstan did not take this path. The MOH has long been opposed to provider autonomy, and other agencies and some development partners are also cautious about it in view of the very limited financial and resource management capacity in most providers and problems with financial control in some providers. Keeping the MHIF and single payer system "on budget" and inside the Treasury management system has been important for providing the Legislature, citizens and external financiers with assurance of probity, transparency and overall financial and fiscal control, in a

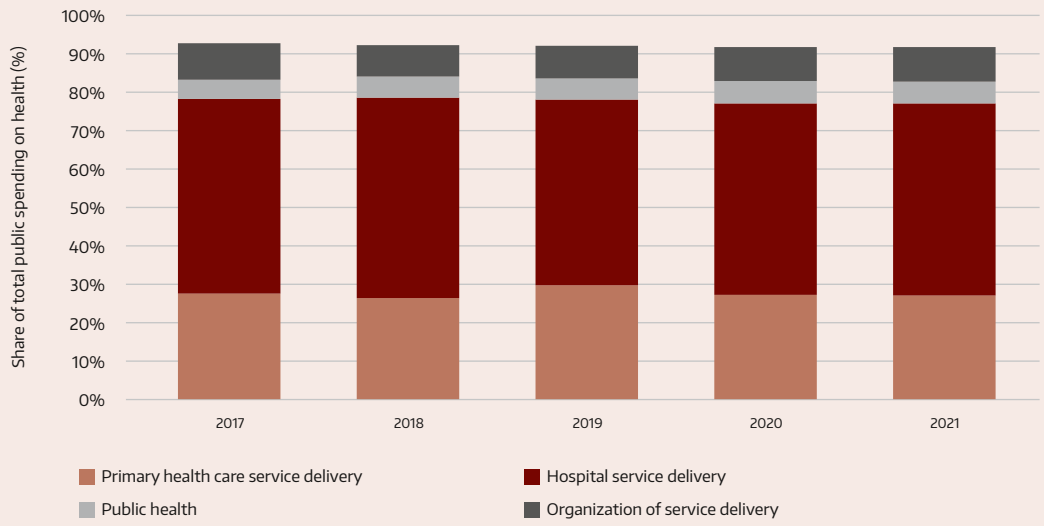
context of very weak financial management capacity at all levels in the health system.

The set of recent reforms adopted as part of the implementation of programme-budgeting have resulted in addressing some of these issues. Firstly, savings from facilities and staff optimization to be retained, although there is residual distrust in the health sector. Secondly, there has been a government-wide move to reduce the level of detail in budget line item controls: the budget is approved and execution controls are applied at a 3 digit level (previously 4 digit level) of the economic classification, which provides more flexibility to spending units. For example, where previously there were three lines related to utilities (2231 payment for water, 2232 payment for electricity, and 2233 payment for heating) there is now one line (223 payment for utilities). Thirdly, ex ante controls of shifts across providers have been removed with elimination of facility-level caps which were previously imposed during the post appropriation stage by the MOF.

Budget transparency has improved: the legislature and the public can link budgets more closely to the purposes of spending. The programme budget for health is available to the public on the Ministry of Finance website. While before it was difficult, if not impossible, to link funding to services, with programme budgeting this became a much easier exercise. For example, now in a matter of minutes an informed user can find the programme budget and identify whether government allocations are supporting priorities such as the outpatient drug package or primary health care. While programme and sub-programme performance indicators need further work, the legislature, civil society, the public and development partners can view these easily and assess how well public money is being used. This will improve further once budget execution data by programme is also made available.

However, programme budgeting is not yet used for budget prioritization and budget allocations do not seem to reflect the stated priorities. As Figure 4.5.1 demonstrates, the share of the PHC programme in total public spending on health remains below 30% and is not projected to increase in the medium-term. Public health receives approximately 6% of total public spending on health and although the new strategy emphasizes population-based interventions, there is no increase foreshadowed in the budget for this programme. Going below the level of programmes and looking at budgetary measures, the Additional Drug Benefit Package which has the potential to be one of the most effective interventions for combatting NCDs and lowering out-of-pocket spending in Kyrgyzstan [21], has been chronically underfunded. In fact, its share in the republican budget has stayed below 2% with no increases forecast in the forward years [11].

Figure 4.5.1: Budget allocation across four main programmes in the Republic budget, 2017 – 2021



Source: [11]

6. RECOMMENDATIONS

Over the past twenty years, Kyrgyzstan has made significant progress in health financing reforms but which many stakeholders felt were impeded by outdated approach to budgeting. Recent budget structure reforms have brought positive changes, as described above. The adoption of the new Budget Code was an important milestone. However, for the effects of the legislative changes to be fully realized in practice, further steps need to be taken. These are described further below.

MOH, MHIF and MOF jointly should review programme and sub-programme definitions to allow improved prioritization of spending on the basis of programmes. Also, where both MOH and MHIF budgets are supporting the same objectives their programme structures should be aligned. Particular attention is needed to review the Programme on organization of service delivery where sub-programmes are mostly procurement of drugs for specific conditions (e.g. insulin provision, provision of immunosuppressants for patients with organ transplantation). PHC and hospital service delivery programmes could also be revised to allow better prioritization of resources. Currently, based on this structure it is hard to determine which programmes should be prioritized. Hospital service delivery programme includes expenditures for the high priority State Guaranteed Package but also a sub-programme on provision of non-medical services by providers under the Single Payer, which is basically paid services and should be viewed more as a source of revenue.

MOF should review the principles and the basis on which budgets are formed to ensure that programmes receive appropriate funding to deliver on the policy commitments and achieve the set targets. When certain service packages are expanded (e.g. free deliveries), then the budget impact of these initiatives should be assessed, and the new budget should take into account these additional resource requirements. Therefore, the principle where each major spending unit receives previous year's budget with some minor adjustments should be gradually replaced with an approach where programmes are carefully assessed and prioritized, and budgets reflect these priorities.

MOH and MHIF in consultations with health providers should prioritise the detailed review of regulations and audit/inspection methods that continue to restrict changes to the input mix. While major laws, such as the Budget Code, have been amended, there are many sub-regulations or linked norms and standards which must be amended accordingly. Currently, there seem to be contradictions between what is allowed under the new Budget Code and the staffing norms still in place, particularly for hospital services. While programme budgeting and output-based provider payment methods encourage efficiency in input mix, reductions in full time staff equivalents may not be possible because of staffing norms still in place. Moreover, as it was revealed during the consultations linked to this study, there is general lack of clarity which regulations are still in place and which regulations have been annulled.

Invest in complementary efforts to strengthen financial management capacity

in MOH, MHIF and healthcare providers, including capacity for better ex post accountability for use of resources. As described in Section 4, MHIF is still cautious about allowing facility managers to shift funds between budget lines without prior approval and even the freedom for virement of +/-5% is not yet used. MHIF partly holds on to the system of prior approvals and strict budget controls because based on its experience it understands that providers do not have strong financial management capacity required for financial autonomy to work. Providers also still have the fear that when the Chamber of Accounts will do the audit it will hold them accountable to old standards of prior approvals for any virement between input lines or between the four sources of funds. This can be alleviated if they have better understanding of how the new budgeting approach works and what rights and responsibilities they have.

The program structure should be used for expenditure control. It is recommended that expenditure is appropriated at the level of programs, which means that the annual budget law passed by the Parliament specifies the allocation of expenditure between programmes, but is silent on the allocation of expenditure within programmes. Currently, Kyrgyzstan appropriates at the level of budgetary measures (the level below programmes but which are a mix of what would be considered sub-programmes and activities). With respect to the breakdown of program expenditure between inputs, performance budgeting in general calls for the relaxation of central input controls in order to give line ministries, such as health, greater managerial freedom to produce services efficiently. This does not mean, however, that all input controls should be abolished: there are almost always limitations on the extent that line ministries can vire into personnel expenditure and away from capital expenditure.

MOF should articulate a clear policy on how performance targets and indicators will and will not be used, and communicate this clearly to budget and programme managers in line Ministries, its own staff, staff involved in inspecting/ auditing, and legislators – to address the legacy of concern about punitive use of performance measurement. Initially, performance measures should be used purely for diagnostic work, i.e. to understand better where the bottlenecks lie and how to improve health services. In later stages, they can be used to inform budgetary allocations but only as one of several other factors. Even in more mature systems in many of the OECD countries, performance measures only play a limited role in budget allocation decisions. In no case they should be used or perceived as being used for administrative sanctions. This will improve quality of performance measures as programme managers will not be as cautious in choosing more ambitious indicators. It is also likely to incentivize accurate reporting.

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ANNEX

HEALTH BUDGET BY FOUR MAIN CLASSIFICATIONS AS REFLECTED IN THE REPUBLICAN BUDGET (THOUS. LCU)

Programme code	Sub-programme code	Budgetary programmes & sub-programmes	2019
Ministry of Finance (transfers to the Mandatory Health Insurance Fund)			
001		**Planning, administration and management**	**152,000**
	01	General management	2,921
	06	Coordination of activities	22,429
	08	General coordination at regional level	88,281
	16	Ensuring planning, approval, financing and execution of consolidated budget under the Single Payer	6,756
	17	Ensuring monitoring and accounting of the MHIF budget	1,842
	18	Ensuring quality control of services provided under the Single Payer	3,254
	19	Ensuring rational and appropriate utilization of funds under the Single Payer	4,963
	20	Communication and raising awareness of the population on their entitlements	3,825
	21	Ensuring adequate functioning of various databases, including on treated cases, additional drug package, contract indicators etc	2,729
	22	Further development of information technologies for strategic purchasing	15,000
002		**Primary health care service delivery**	**5,539,025**
	01	Ensuring access to emergency care	448,499
	02	Ensuring access to basic medical services at PHC level	4,309,514
	03	Ensuring access to TB treatment at PHC level	33,372
	04	Ensuring access to drugs for certain conditions (cancer patients in terminal stages, mental health patients, epilepsy and asthma) under the SGBP	55,000
	05	Ensuring access to Additional Drug Package under the Mandatory Health Insurance	276,070
	06	Provision of services beyond the SGBP	77,291
	07	Provision of non-medical services by providers under the Single Payer	239,280
	08	Quality improvement through financial incentives related to performance	100,000

Programme code	Sub-programme code	Budgetary programmes & sub-programmes	2019
003		**Hospital service delivery**	**9,021,615**
	01	Ensuring access to hospital services under the SGBP	6,440,182
	02	Ensuring access to TB treatment at hospital level	690,174
	03	Ensuring access to specialized hematology and oncology services	172,714
	04	Ensuring access to specialized cardiac surgery services	55,106
	05	Ensuring access to specialized mental health services	279,692
	06	Paid services beyond the services included in the SGBP	535,794
	07	Provision of non-medical services by providers under the Single Payer	747,952
	08	Improvement of quality of care through pay-for-performance	100,000
004		**Ensuring access to medical and other services beyond the SGBP**	**286,000**
	01	Ensuring access to subsidized treatment for patients in end-stage chronic renal failure, receiving care in private facilities while awaiting availability of services in public facilities	286,000
Ministry of Health			
001		**Planning, administration and management**	**91,646**
	01	General management	8,247
	02	Ensuring financial management and accounting	5,281
	04	Legal support	2,278
	06	Coordination of activities	5,803
	07	Monitoring and strategic planning of the sector	5,088
	26	Clerical work	7,041
	27	Ensuring monitoring and control (Internal audit services)	3,023
	28	Introduction of electronic systems, including electronic patient card, database of enrolled population, human resources etc	28,276
	29	Licensing of private medical practice	1,887
	30	Social and cultural support to medical workers	24,722
002		**Public health**	**1,028,256**
	01	Measures to ensure safety standards for human health (food safety, indoor air, water, radiation levels)	541,374
	02	Immunization policies	179,031
	03	Population awareness and education on health promotion	46,717
	04	HIV prevention, diagnosis, treatment and care	169,301
	05	Comprehensive package of health services and care for special patients	3,000
	06	Measures for epidemiologic surveillance and prevention of vector-borne diseases (plague)	70,630
	07	Ensuring quality control of laboratory services for diagnosis of infectious diseases including HIV, brucellosis, hepatitis, syphilis	18,203

Programme code	Sub-programme code	Budgetary programmes & sub-programmes	2019
003		**Organization of service delivery**	**1,572,628**
	01	Improved quality of care at PHC level	70,741
	02	Early detection of diabetes	10,149
	03	Early detection of TB among vulnerable population groups (procurement of diagnostic tests, specifically Mantoux screening test)	12,100
	04	Ensuring access to medicines and medical supplies in health care organizations	120,000
	05	Ensuring access to blood and its components	150,889
	06	Maternal and child health services	106,488
	07	Rehabilitation services	274,893
	08	High technology services for patients from socially vulnerable population groups	586,172
	09	Insuline provision	69,400
	10	Forensic examination services	72,596
	11	Provision of antihemophilic drugs	28,600
	12	Provision of supplies for chemotherapy	2,700
	13	Provision of immunosuppressants for patients with organ transplantation	67,900
004		**Medical education and human resource management**	**947,937**
	01	Improved process for human resource management in health	31,749
	02	Graduate level medical training	467,765
	03	Continuous medical education and in-service training	149,161
	04	Undergraduate medical training	299,261
005		**Infrastructure project implementation**	**962,152**
	01	Implementation of state investment projects	962,152

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