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Health financing in Kyrgyzstan: obstacles and opportunities in the response to COVID-19

Kyrgyzstan

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HEALTH FINANCING IN KYRGYZSTAN: OBSTACLES AND OPPORTUNITIES IN THE RESPONSE TO COVID-19

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Abstract

The COVID-19 crisis has re-emphasized the absolute necessity for strong, adequately funded and resilient health systems that can respond quickly and equitably to emergencies while ensuring financial protection for all. Kyrgyzstan has taken important decisions to increase public funding for the health system response to COVID 19, including increased donor support. Sufficient public funding for the country response to the COVID-19 outbreak is needed to support scaling-up and delivery of population-based and individual services. This brief aims to provide a basis for discussions among national policy-makers, international donors and other development partners on how to increase efficiency in health financing to improve the response to COVID-19 in Kyrgyzstan. It highlights how challenges to the existing health financing model may have hampered the COVID-19 response in the country and presents recommendations to overcome them and increase the overall resilience of health systems, including emergency preparedness and response.

Keywords
HEALTH FINANCING
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Health financing in Kyrgyzstan: obstacles and opportunities in the response to COVID-19

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Contents

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Acronyms

ADB	Asian Development Bank
ADP	Additional Drug Package
GDP	gross domestic product
IMF	International Monetary Fund
MHIF	Mandatory Health Insurance Fund
OOP	out-of-pocket (payments)
PPE	personal protective equipment
PHC	primary health care
SGBP	State Guaranteed Benefit Package

Executive summary

The COVID-19 crisis has re-emphasized the absolute necessity for strong, adequately funded and resilient health systems that can respond quickly and equitably to emergencies while ensuring financial protection for all. It has shown that poverty is exacerbated both directly, through the costs of treatment for illness where co-payments and informal payments are required, and indirectly, through lost income. The disease by itself is associated with poverty, further perpetuating the vicious cycle. Ensuring adequate public funding of primary, secondary and tertiary care therefore is vital to ensuring financial protection.

Kyrgyzstan has taken important decisions to increase public funding for the health system response to COVID 19, including increased donor support. Sufficient public funding for the country response to the COVID-19 outbreak is needed to support scaling-up and delivery of population-based and individual services. Sustained investment in primary health care is key to delivering pandemic preparedness and response while ensuring continuity of essential services, including contact-tracing, prevention and communication.

This brief aims to provide a basis for discussions among national policy-makers, international donors and other development partners on how to increase efficiency in health financing to improve the response to COVID-19 in Kyrgyzstan. It highlights how challenges to the existing health financing model may have hampered the COVID-19 response in the country and presents recommendations to overcome them and increase the overall resilience of health systems, including emergency preparedness and response.

Introduction

The first three cases of COVID-19 were recorded in Kyrgyzstan on 18 March 2020. Four days later, on 22 March, the Government declared a public health emergency and imposed strict measures to control the spread of infection. The COVID-19 response agenda temporarily pushed regular health system activities aside and repurposed capacity to combat the pandemic.

Measures to combat the pandemic are being deployed against a backdrop of pre-existing funding deficits and inefficiencies. Domestic resource mobilization for health in Kyrgyzstan had been weakening progressively prior to the COVID-19 crisis. Public spending on health was at its highest in 2012 – 4.2% of gross domestic product (GDP) – but has decreased since then to 2.8 of GDP in 2018. Public spending on health as a share of current health expenditure has declined since 2011. The disruption in trade and mobility brought about by the pandemic has resulted in an anticipated US$ 500 million financing gap in the state budget for 2020 (7% of GDP). To bridge this gap, the Government has requested additional funding from its bilateral and multilateral development partners.

Under normal circumstances, all activities aimed at containing the spread of infectious diseases are funded through the Ministry of Health. The Epidemic Fund of the Ministry of Health is extremely limited. It received 30 million Kyrgyz soms (US$ 500 000) on 3 February 2020 but this sum quickly became depleted. Additional donor funding also goes through the Ministry of Health into public health services, and some donors channel ad hoc in-kind donations, such as medical equipment and personal protective equipment (PPE), through the Ministry of Health.

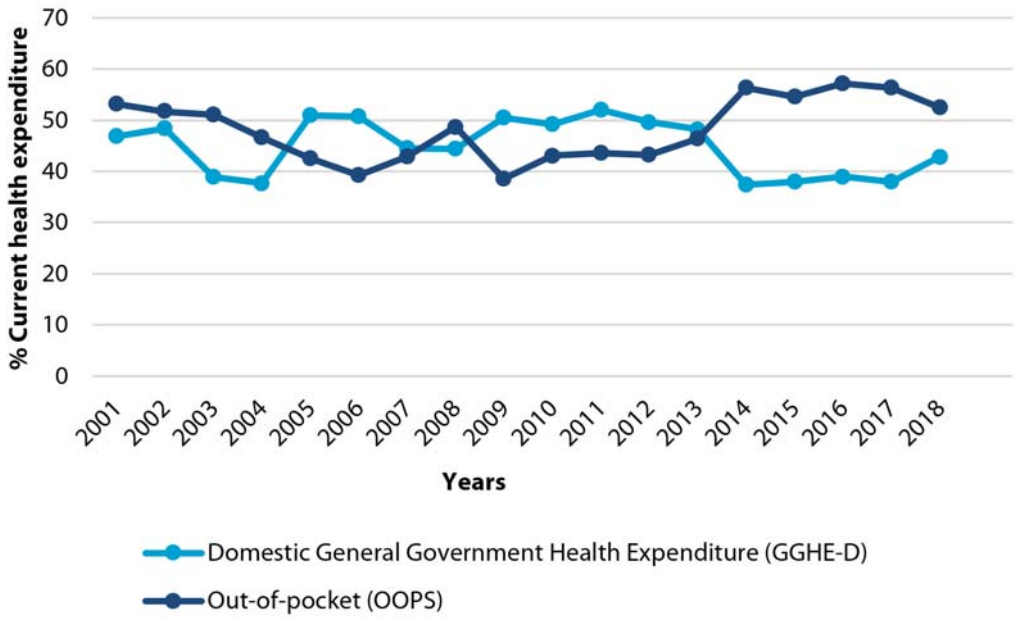
Background

Health expenditure and general trends in spending

There are three principal sources of funds for health in Kyrgyzstan: the public sector, private funds and external funds. Public sources include the republican budget funds or republican budget (based on general tax revenues) and mandatory health insurance funds (based on income tax revenues). Private funds mainly take the form of direct out-of-pocket (OOP) payments for primary, secondary and tertiary care, and for pharmaceuticals. These OOP payments can be formal (official co-payments or payments for nonmedical services) or informal. The largest share of private payments is used for outpatient drugs. External funds comprise funds from international organizations and donors.

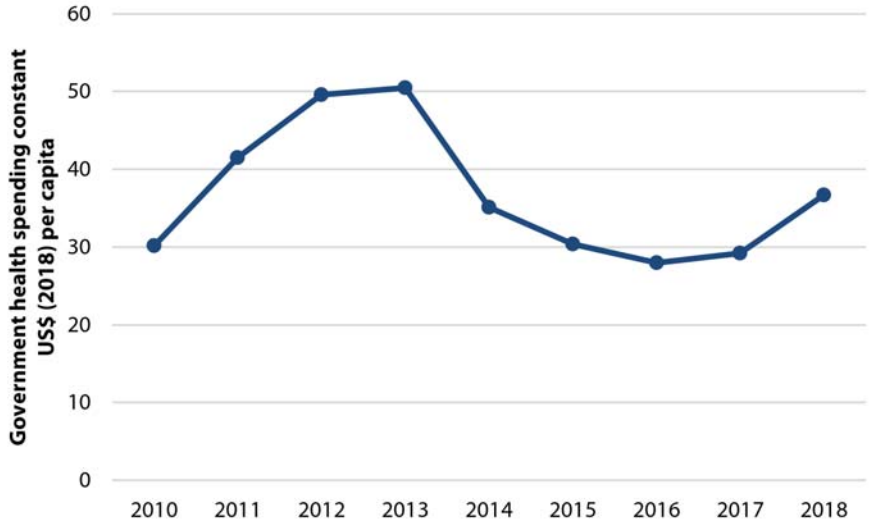
External health expenditure as a percentage of current health expenditure has oscillated between a maximum of 15% in 2003 to 4.7% in 2018(1). Domestic resource mobilization for health in Kyrgyzstan had been weakening progressively prior to the COVID-19 crisis. Public spending on health was at its highest in 2012 at 4.2% of GDP, but had decreased to 2.8% of GDP in 2018. Public spending on health as a share of current health expenditure has declined significantly from 52% in 2011 to 43% in 2018 (Fig. 1). This has resulted in declines in real government spending on health per capita (Fig. 2).

Fig. 1. Domestic public and OOP spending on health in Kyrgyzstan (2000–2018)



Source: WHO (*1*).

Fig. 2. Government spending on health per capita in Kyrgyzstan (2010–2018)



The long-term spending target for the health sector was not achieved fully by the Den Sooluk reform programme (2011–2018) and the supporting sector-wide approach, which called for the Government to allocate 13% of its budget to health. The 13% target, agreed between the Government and development partners, was interpreted as a ceiling rather than a floor, as evidenced by the flattening trend in real terms in resource mobilization from the republican budget since 2012. This target was used until the end of 2018, when the Den Sooluk programme ended. In 2019, there was a shift in the donor support discourse and the spending target as a conditionality. Currently, the World Bank uses a payment-for-results principle using nine disbursement linked indicators.

Declining transfers from the state budget are the main driver of shrinking health budgets. Contributions play a very small role in forming the health budget (see below).

Pooling of funds

Funds flow from the republican budget to the Ministry of Health, the Mandatory Health Insurance Fund (MHIF) and other ministries and agencies. The lion's share of the MHIF budget revenue (70.5%) comes from the republican budget (*2*). It is used to fund the State Guaranteed Benefit Package (SGBP) of health services, the Additional Drug Package (ADP) and mandatory health insurance contributions for some population groups. The state contributes on behalf of children under 5 years of age, pensioners, students, soldiers and veterans, who are also eligible for additional benefits such as free services or reductions in co-payments. The MHIF also pools insurance premium contributions into a Social Fund that is collected by the Tax Inspection Service from the working part of the population – a 2% social tax is levied on all personal income and makes up 16% of the MHIF budget (Financial Policy Department, Ministry of Health of the Kyrgyz Republic, unpublished data, 2018). The remaining 11% of the MHIF budget comes from co-payments, special earmarked funds and insurance premiums that those in the informal sector can purchase directly from the MHIF.

The MHIF channels 80% of public spending through a contractual relationship with health facilities on all levels of care, under which individual health services covered by the SGBP and ADP are purchased. It is also responsible for financing tertiary care facilities. The Ministry of Health is responsible for financing costly (high-technology) health services and health services provided to the whole population, including the centralized procurement of a few pharmaceuticals, expensive medical equipment and other capital investments. It is also responsible for financing health organizations that are paid from the republican budget and do not provide health services under the SGBP.

Population coverage and entitlement

Health coverage is regulated by the SGBP and the ADP. Under the SGBP, all citizens are entitled to: free emergency care; a free basic package of primary care services (which includes a limited selection of medicines); free outpatient specialist care with referral; and inpatient care with referral and co-payments. Groups of people with high expected health-care costs are exempt from, or entitled to reduced, co-payments for inpatient care. People who have paid their mandatory health insurance contributions[1] (around 66% of the population in 2018 (*3*)) are entitled to 61 outpatient medicines at reduced prices under the ADP and to reduced SGBP co-payments for inpatient care. Thirty-four per cent of the population, comprising relatively vulnerable groups of people, have access only to the SGBP and are not able to benefit from lower co-payments for hospital care or from access to the subsidized outpatient medicines covered by the ADP that come with mandatory insurance coverage.

Although contributions play a very small role in forming the health budget, they nevertheless are worth highlighting; the COVID-19 crisis has exposed how linking contributions to entitlements is an inequitable method of health financing. Collection of mandatory health insurance contributions was weak even prior to the crisis, which can be attributed in large part to difficulties in collecting contributions from the informal labour force. Economic growth in Kyrgyzstan relies partly on heavy exploitation of the country's natural resources, which does not translate into labour-force growth (*4*), so jobs have not been created in the formal sector. Most employment growth has taken place in the informal sector (estimated to be around 50% of GDP), a section of the labour force that does not contribute to health insurance funds and therefore is not entitled to the corresponding services and discounts.

Costing and financing gaps in the SGBP and ADP leave patients with either unmet health need or OOP payments for health services. OOP payments grew substantially in Kyrgyzstan between 2000 and 2014. They currently account more than 50% of total spending on health. As a share of household spending, OOP payments fell between 2000 and 2009, largely driven by a decline among the three poorest quintiles, but they increased sharply from 2009 to 2014 for all quintiles, undermining earlier achievements. Deterioration in financial protection since 2006 has been driven by high and growing OOP payments for medicines, particularly outpatient medicines and medicinal supplies. These were the main areas of reduction in OOP payments by 2006 following reform implementation, although they remained the largest contributor to OOP payments (*6*). For upper-income quintiles and in the cities of Bishkek and Osh, growing OOP payments for dental care, diagnostic tests and outpatient care are

[1] Collection of the social tax was moved from the Social Fund to the Tax Inspection Services in 2019, a move that is expected to improve transparency and efficiency in tax collection.

contributing to rising catastrophic expenditure. OOP payments on medicines, supplies and personnel have also grown in the hospital system. Between 2006 and 2013, the financing gap in hospital care met by informal payments increased from 25% to 35% of total hospital spending that should in theory be covered by the SGBP (*6*).

Persistent informal payments for hospital services illustrate a shortfall in SGBP funding (*5*). They contribute to catastrophic OOP payments and their informal nature makes it difficult to protect poor households.

Strategic purchasing and payment of health services

Public health services and some individual services are provided by the Ministry of Health and funded through the republican budget. The MHIF manages a split between purchasing and provision, realized by the introduction of output-based provider-payment systems through which the MHIF acts as a single payer of all individual health services.

The MHIF budget allocated to primary health care (PHC) relative to hospital services has not increased sufficiently to enable the role of PHC to expand. In 2019, for example, the share was 35.3% of total expenditure going to PHC and 58.3% to the hospital sector (*6*). The range of services included in the SGBP, and therefore not subject to payment, is relatively narrow. This means that uninsured patients in need of services that are not included in the package either present with unmet need or are left to cover the cost of these services out of pocket.

Effective strategic purchasing of both individual and public health services is hampered by the lack of systematic use of analysis and evidence as a basis for forecasting demand and cost drivers, and by costing and financing gaps in the SGBP and ADP. These gaps often lead to implicit rationing and informal payments. Limited progress in using contracting and the provider-payment system in hospitals and PHC facilities slows improvements in quality, efficiency and health outcomes.

The main obstacle to strategic purchasing development, however, is the excessive, inefficient and fragmented hospital infrastructure, meaning that hospitals are funded irrespective of their performance. In other words, excess hospital capacity thwarts purchasing arrangements that aim to support transformation to a model of care that is PHC-based and outpatient-centric. There is no provider-payment mechanism for outpatient specialist care or same-day surgery, for example, providing hospitals with a strong incentive to admit inpatients who could be treated as outpatients or same-day cases.[2] At the same time, hospitals often exceed the number of patients specified in their contracts, which leads to increases in unplanned MHIF expenditure due to effective volume-control mechanisms not being in place. Case-based payment for hospital services, while reducing unjustifiably long hospital stays, has led to a growth in admissions and unnecessary referrals to hospital from PHC facilities.

[2] The exception is a United Nations Children's Fund-supported project that has increased hospital day-treatment rates and supported associated service delivery changes, with significant impacts in reducing avoidable hospitalizations.

A lack of communication between Ministry of Health and MHIF databases prevents services from following the patient through their journey from primary to tertiary care, and vice versa. This disconnect precludes any systematic analysis to control the volume of services, provide feedback to providers or shift the mix of inpatient care to improve cost–effectiveness and address health priorities (*7*). Expansion of the role of PHC has also been hampered by characteristics of the capitation formula for payments, including low rates of payment and poor monitoring of performance. Since 2018, however, the MHIF has been using pay for performance for PHC[3]. A systematic evaluation should shed light on improvements achieved with the new method.

The ADP's ability to ensure financial protection is limited because of the low level of funding allocated to it. Generally, it covers less than 50% of the retail price of medicines; 34% of the population is not entitled to it, and in practice it reaches only a fraction of those who are entitled to it due to budget caps and provider-level rationing. Medicine prices and distribution mark-ups are unregulated, exposing people and the public purse to higher-than-necessary costs.

Publicly financed outpatient medicines require a prescription, but only account for a small share of the medicines market; other medicines can be obtained without a prescription. Growth in household spending on outpatient medicines was much faster for medicines obtained without a prescription than for prescribed medicines between 2006 and 2014. The cost of medicines has been increasing, largely due to, on the one hand, the absence of regulation of wholesale and retail prices and pharmacy mark-ups and, on the other, currency fluctuations and devaluation in a market heavily reliant on imported medicines. In addition to changes in prices, there may have been changes in patterns of use, possibly linked to weak enforcement of prescribing.

Greater financial protection can be achieved by increasing government funding for PHC, expanding the services provided under the SGBP and medicines included in the ADP, and increasing the affordability of inpatient medicines, which is hampered in part by inefficiencies in their procurement. The pharmaceutical market in Kyrgyzstan is private; there is nearly total reliance on imports, with residual levels of national production (*8*). Procurement for some medicines is centralized by the Ministry of Health. Preliminary analyses of procurement undertaken so far shows gains for the Ministry of Health in terms of prices (*9*).

Hospitals procure their medicines individually. Attempts to centralize hospital procurement have failed in the past due to the high transportation prices to more remote hospitals. The potential of centralized procurement should be thoroughly analysed.

[3] Abolished in 2021 and replaced by a flat 100% increase of in the basic salary of family doctors

Interactions between pre-existing challenges to health financing and the COVID-19 response

Low and decreasing public funding

Short- and medium-term impacts on domestic resource mobilization for the health sector

In 2019, the MHIF had a total approved budget of 15 720.5 million Kyrgyz soms (US$225 million), of which 15 233.6 million Kyrgyz soms (US$ 218 million) (96.9%) was executed. Of this, 10 739.2 million Kyrgyz soms (US$ 154 million) (70.5%) came from the republican budget and 2320 million Kyrgyz som (US$ 33 million) (15.2%) from the Social Fund contribution. The remainder came from co-payments and other contributions (*6*).

Funding shortfalls, mainly from the republican budget and, to a lesser degree, from mandatory insurance contributions, resulted in an underfunding of the MHIF compared to its approved budget in 2019.[4] This contributed to an inability to fund the SGBP and the ADP adequately even before the crisis hit.

According to preliminary data for the first quarter of 2020, the crisis had aggravated the fiscal situation in the country. The revenue of the republican budget fell by 10% relative to the same period in the previous year. Almost 80% of all revenue losses can be attributed to losses of value added tax on imports from non-Eurasian Economic Union countries and other taxes on international trade. At the same time, republican budget expenditure on investments unrelated to the epidemic increased by 4.9 billion soms. These included increases in spending on salaries in education and capital investments in the framework of the Public Investment Programme (*10*).

In May 2020, the Government submitted a draft law on amendments to the republican budget for 2020 and budget forecast for 2021/2022 to the parliament. Overall, the Government approved a budget of 5692.2 million soms (US$ 71.4 million) for the COVID-19 emergency response. An additional 2061.6 million soms (US$ 25.93 million) was allocated directly for health (an increase of 13% from the approved budget) (*11,12*).

[4] The execution of MHIF revenue from the republican budget was 15 234 million soms against a planned 15 720.5 million soms. After a mid-year MHIF request to the parliament for a budget law amendment, a parliament resolution ordered the Ministry of Finance to fill the gap. Because of the late transfer of funds (1200 million soms) in December, however, it was impossible for the MHIF to absorb the total amount, resulting in 390 million soms of unspent funds being taken back to the republican budget.

The most recent International Monetary Fund (IMF) forecast for 2020 predicts a 12% decline in GDP, while the Asian Development Bank's (ADB's) latest estimate of GDP decline is 5%. This impact assessment takes a GDP reduction of 10% as its baseline scenario (*13*).

Labour-market challenges and new policies to ease the negative social consequences of the COVID crisis affect funding for the MHIF. According to the Eurasian Economic Commission, the number of unemployed people in Kyrgyzstan may increase by 500 000, or about 20% of those currently in employment. This loss of employment alone is expected to lead to a 26% decline in tax revenue (*14*).

After the onset of the COVID-19 pandemic, the Government prepared several packages of measures to combat its negative socioeconomic effects, including enabling taxpayers to defer tax payments for a one-year period. This has implications for health financing (*15*), as part of the MIHF budget inevitably will decline in line with the reduction in income tax collection. In addition to decreasing republican budget revenues, the revenue collection forecast from the Tax Inspection Service is not optimistic. Following unemployment and cuts in incomes, premium collection has deteriorated. The Social Fund's debt to the MHIF increased by 183 million soms in the first four months of 2020, as only 674 million of 856.6 million soms budgeted was transferred.

Role of donor funding in filling the gaps in the health budget

To close the anticipated US$ 500 million financing gap from the disruption to trade and mobility, the Government has requested additional funding from its bilateral and multilateral development partners: IMF direct budget support of US$ 241.8 million, and US$ 50 million from the ADB, World Bank, bilateral donors and the United Nations system (*10*). The expected inflow of additional foreign aid, equivalent to 7% of GDP, may fully compensate for any internal revenue losses.

Development partners have so far pledged US$ 45 million to support the health sector response to COVID-19, with most of these funds going to areas such as the purchase of medical devices, medicines, training and laboratory services. Some contributions are planned over 2–3 years. This contribution exceeds the initial request for US$ 15.8 million for 2020 formulated in the contingency plan (*16*).

Pooling of funds and financial management

By design, the current pooling arrangement at the MHIF is fit for responding to an emergency. It is mandated to pool money from different sources, ranging from the republican budget to private contributions, which not all agencies in Kyrgyzstan legally are able to do. This means that the MHIF has, de jure, the ability to pool specific funds that could be used to purchase services to treat and prevent COVID-19 cases.

Of the US$ 55.2 million spent on the multisectoral COVID-19 response, 16% of the budget was spent by the Ministry of Health and 38% was channelled through the MHIF (*11,12*). The World Bank and ADB projects have attempted to set up funding mechanisms for hospitals through the MHIF to meet local needs, but report that those mechanisms have not been used after five months of being formally funded (the World Bank, personal communication, 2020). The reason for this lies in the pandemic itself. Due to COVID-19, the response capacity of the MHIF was reduced severely for two reasons. First, many staff members were infected, resulting in a human resource shortage. Secondly, the crisis changed the usual communication lines. Additional reporting demands and participation in new working groups were placed on already reduced numbers of staff. This meant there was no capacity to absorb the new funding mechanisms and the administrative procedures that accompany them, resulting in additional funds not being channelled through the single-payer system and its contracting with health facilities. There is a lesson in sustainability to be learned from this case: the MHIF should be involved in processes involving them from the outset, and their capacity in terms of human resources and logistics needs to be strengthened to prepare the system for a future outbreak.

Short- and medium-term impacts on domestic resource mobilization for the health sector

Recent research for WHO and the Center for Global Development (*17*) shows that increasing overall expenditure envelopes is usually the main driver of higher allocations of funding for health, especially among low- and middle-income countries such as Kyrgyzstan. Given the impact of the crisis on public finances described in the introduction, it is very unlikely that overall expenditure will increase. Consequently, increased allocations for health could come from two sources.

The first is increasing the share of the expenditure envelope dedicated to health by reallocating funds away from other functions. WHO research shows that reallocation of funds towards health is not only a matter of political choice, but also depends on Ministry of Health capacity to prepare and negotiate budget proposals. For example, removal of the target for allocation of 13% of the Government budget to health added to the decline in Government health expenditure since 2019. Development partners could play a role in the short term in providing technical assistance to support these preparations and, in the medium term, assist with capacity-building for budget preparation and negotiation.

The second source involves enabling increased spending on health by budgeting better. Implementing more efficient rules in public financial management by ensuring that health funding allocations are reliable, timely, flexible and strategic can enlarge the health sector's budgetary space, especially if accompanied by thorough planning and execution of health budgets by the Ministry of Health. The current World Bank public expenditure review provides an opportunity and the data for budgetary space diagnostics.

In the medium-to-long term, options to increase fiscal space include a feasibility study for increased tobacco and alcohol taxation, in line with WHO best buys for the prevention and control of noncommunicable diseases (*18*).

Strategic purchasing

Similarly to what happened in many countries, the pandemic response has focused, at least initially, on hospital capacity. While inpatient services for severe COVID-19 illness must be available, PHC and outpatient services protect hospital bed availability for critical cases. Excess hospital capacity, however, is absorbing resources that could strengthen the PHC response.

The overflow of patients in hospitals during the COVID-19 crisis does not indicate a shortage of hospital capacity as much as a failure of PHC capacity to be at the front line of the response. In other words, strong PHC services play a vital role in testing, managing people with mild or moderate cases of COVID-19, contact-tracing, and implementing communication and prevention measures. Ultimately, PHC services slow the spread of the virus and reduce the risk of saturation and eventual collapse of health-care infrastructure, particularly hospitals.

The unique and pervasive nature of COVID-19 warrants new approaches to managing it at PHC level. Given the potential of COVID-19 to overwhelm health services, it is essential that the roles and responsibilities of PHC be adapted to make the best use of limited resources. Strengthening the capacity of PHC can enable wider access to testing and adequate care for people with mild or moderate illness without the need for hospitalization. People with mild and moderate illness need to be isolated at home or in other safe housing until they have recovered and, during this period, they will also need to have access to their PHC providers. Some countries have organized outreach services where health workers visit patients in isolation at home on day 5 or 6 of their illness – a critical point in the development of the disease – to take a blood test, measure blood oxygen saturation levels and look for other symptoms that indicate a patient might soon become severely ill, enabling the patient to be hospitalized before this occurs (19). Incorporating PHC officials and experts into the national pandemic response team and enabling PHC professionals to provide care for mild COVID-19 patients will take pressure of hospitals, freeing them to deal with more severe and critically ill COVID-19 patients.

Although additional donor resources and reallocations from other sectors were mobilized for the multisectoral response to COVID-19, the ability of the MHIF to enhance the role of PHC was severely weakened because its resources were depleted by paying for the treatment of COVID-19 cases. The initial MHIF allocation from its insurance emergency funds to cover 4500 COVID-19 cases during 2020 soon ran out and the MHIF shortly thereafter incurred substantial deficits.

The rates for payment for COVID 19 cases in Box 1 serve as an indication of the stress this has put on the emergency fund.

Box 1. MIHF reimbursement rates for COVID-19 patients

The reimbursement rates are based on:

- mild form of the disease – 3500 soms
- average form – 10 818 soms
- severe form – 70 427 soms
- very severe form – 132 837 soms.

The reimbursement rates include medicines, utilities and food, PPE, tests and salaries for health workers.

Source: Ministry of Health of the Kyrgyz Republic (*20*).

Extraordinary budget allocations from health-care facilities also deserve a mention, as health providers spent funds allocated for purchasing medicines and other expenditure to purchase PPE and medicines for treatment of COVID-19 patients.

In addition to paying for COVID-19-related services, the MHIF is still paying secured budget lines to hospitals even though hospitals are not providing the planned services. In response to the COVID-19 pandemic, the hospitalization rate in Kyrgyzstan decreased by 40% in April 2020, driven by changed health-seeking behaviours and access restrictions to mitigate the risk of infection. The MHIF nevertheless continued to fund secured budget lines as wages, medicines, food, disinfection processes and PPE during April. The MHIF therefore has played an important role in securing capacity in medical facilities and not draining their resources in response to the decrease in cases.

While the MHIF largely has protected funding to facilities by maintaining payment for secured budget lines, it has also paid additional funds to hospitals for treatment of COVID-19 patients. The newly established rates and total costs add up to large amounts, but the MHIF has received insufficient additional funding. Similarly, health providers, including those at PHC level, have spent funds allocated for purchasing medicines and other expenditure to purchase PPE and medicines for treatment of COVID-19 patients.

Channelling donor funds through the MHIF – including salary top-ups – has the advantage of using existing funding mechanisms that can trace payments from the pool of funds to the case payment, which in turn increases transparency. It is important that Ministry of Health and MHIF reporting systems are aligned, ensuring no duplications and no unnecessary administrative burden on providers. The Ministry of Health and the MHIF should have access to the data they need for their functions and be able to deliver reporting that satisfies the requirements of the Ministry of Finance and development partners and meets standards for public reporting.

Weak financial protection and gaps in coverage policy

The steep increase in unemployment and increased numbers of migrants returning to the country brought about by the pandemic have left many people without health coverage. Inability to pay insurance premiums will result in the reversal of reductions in co payments for hospital services and selected pharmaceuticals. The pandemic has also caused the return to Kyrgyzstan of many migrant workers who are not eligible for reduced co payments.

There have been no changes in coverage (in the sense that services under the SGBP have remained the same), and the Government is providing COVID-19 health services free of payment. Even so, the pandemic has exposed weaknesses in the financial protection afforded by the health-care system in Kyrgyzstan: for example, even before the crisis, expenditure on OOP payments for outpatient medicines was excessive. With no additional investment in drugs purchasing, it is likely that the pandemic will have exacerbated this situation.

Expansion of the SGBP should focus on priority services that reflect the burden of disease, including equity-related factors to support a strong focus on needs-based health provision. The selection process should use criteria such as cost–effectiveness, priority to the worse-off (such as stateless people, migrant workers and rural populations) and financial risk protection. This will allow an expansion of coverage for high-priority services to everyone, eliminating OOP payments while increasing mandatory, progressive pre-payments with pooling of funds.

Lessons learned and recommendations

The COVID-19 crisis has re-emphasized the absolute necessity for strong, adequately funded health systems that can respond quickly and equitably to emergencies while ensuring financial protection for all. It has shown that poverty is exacerbated both directly, through the costs of treatment for illness where co-payments and informal payments are required, and indirectly, through lost income. Ensuring adequate public funding of primary, secondary and tertiary care is therefore vital to ensuring financial protection.

Kyrgyzstan has taken important decisions to increase public funding for the health system response to COVID 19, including increased donor support. Sufficient public funding for the country response to the COVID-19 outbreak is needed to support scaling-up and delivery of population-based and individual services. Sustained investment in PHC is key to delivering pandemic preparedness and response while ensuring continuity of essential services.

Recommendations for the short and medium term and for the long term are as follows.

Funding

Increase funding to secure an adequate overall level of public funding for population-based and individual health services

Improve alignment of financing streams to address current challenges posed by the channelling of donor funding in parallel to MHIF contracts

More efficient rules in public financial management can be implemented by ensuring that health funding allocations are reliable, timely, flexible and strategic. This can enlarge the health sector's budgetary space, especially if accompanied by thorough planning and execution of health budgets by the Ministry of Health.

This should include improving the coverage policy to ensure: all people have access to essential care without experiencing financial hardship; better alignment of financing streams to address current challenges, even if donor funding is channelled in parallel to MHIF contracts; and a programme budget line for the MHIF is established and funded to recover its now depleted emergency fund, meaning it can continue to pay for current and predicted subsequent waves (these funds should be added to the existing MHIF budget, which did not account for costs incurred during the COVID-19 crisis).

Increase funding for PHC services to reflect the increased functions of PHC in tackling the pandemic while securing continuity of other essential services

This includes increasing government funding for both population-based and individual health services. Resources could be mobilized to primary care settings to enable it to attract services from secondary and tertiary levels to meet the need for screening, testing, treating mild and moderate cases at PHC level and the need to maintain other essential services.

Complement increased funding with increased capacity-building for PHC health workers and safe working conditions for front-line workers, including PPE provision

Donor funds should also be channelled through the single-payer system adequately to fund and expand the reach of the PHC system.

Adequately fund the gatekeeping function of PHC for COVID-19 and essential services

This includes funding PHC units to optimize the existing network of PHC providers and to select the most appropriate ways to establish testing sites, considering options such as designated tent areas or mobile teams to enable testing at home for people whose mobility is limited. It may be desirable to arrange transportation to PHC providers or testing sites to reduce the need for people to use public transportation. PHC should also be included in the organization and service delivery for newly established ad hoc health-care and non-health-care facilities (such as temporary shelters and hotels) for mildly or moderately ill patients. Enabling PHC to fulfil its gatekeeping functions also includes assisting units to establish screening of all patients on arrival at all sites using the most up-to-date COVID-19 guidance and case definitions, contact-tracing, and supporting information, education and communication campaigns. Patient-care pathways for COVID-19 and demands for regular PHC should be separated through using digital technologies such as telephone triage and video consultations. PHC services should be coordinated with extra-hospital emergency care (ambulance, telephone helplines for urgent care and information and requisition of ambulances for transportation) and with social care and public health services for the most vulnerable people.

Population coverage and entitlements

Remove all financial barriers to diagnosis and treatment of COVID-19 cases

This includes adequate funding for inpatient drugs to prevent rationing and subsequent informal payments.

Adequate funding of well defined entitlements under the SGBP and ADP and decouple entitlements and contributions

As it is, there is a gap between the de jure universal entitlement to the SGBP and de facto universal access to quality services. In order to improve the alignment between the two and reduce informal payments, it is important to better define and disseminate what services should be available at public facilities.

Once these measures are in place, there a base from which to expand fully funded services under the SGBP will reduce reliance on services covered by mandatory health insurance and pave the way for a decoupling of entitlement and contributions.

The design of the expansion of the SGBP should focus on priority services

These services should reflect the burden of disease, including equity-related indicators. The selection process should use criteria such as cost–effectiveness, priority being given to the worse-off (such as stateless people, migrant workers and rural populations) and financial risk protection. This will allow an expansion of coverage for high-priority services to everyone, eliminating OOP payments while increasing mandatory progressive pre-payment with pooling of funds.

Expand the basis of registration in the informal sectors of the economy to allow undocumented people to benefit from the SBGP

Purchasing and payment

Strengthen the capacity of the MHIF to improve its efficiency as a strategic purchaser

This includes improving and optimizing information systems feeding decision-making and improving reporting systems to improve transparency in purchasing decisions.

Simplify public procurement systems and custom clearance procedures for medicines and health technologies

Improvement of public procurement regulation will allow the country to benefit fully from collaboration with international procurement platforms.

Conduct an analysis of the benefits of centralized procurement (including an analysis of mechanisms for hospital needs assessment for inpatient medicines)

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