Webinar #1 in the CIS:
Questions and Answers from Speakers

Social health protection and health financing reforms in CIS countries
with participation of panellists from Azerbaijan, Kazakhstan, Kyrgyzstan

Question 1 (Joseph Kutzin) to all three panellists:

In 2010, we synthesized the main lessons from health financing reforms from the first 20 years following the end of the USSR. This is available for free download in English and Russian languages here: https://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2010/implementing-health-financing-reform-lessons-from-countries-in-transition-2010

Whether there are critical changes in the directions of reform since that time (since 2010): one in particular is the ability to understand active, strategic purchasing by national health insurance funds, even where - as in Kyrgyzstan and Moldova - these are funded mainly from general tax revenues.

What are key developments over the past 10 years in strengthening the ability to purchase services more effectively by health insurance agencies? Have information technology developments been adequately used?

Answer by **Nigar Bayramova**, Deputy Chairman of the Executive Board of the State Agency on Mandatory Health Insurance of the Republic of Azerbaijan:

We have just started to introduce strategic purchases. Currently we are collecting analytical data to assess the need of the system to further strengthen strategic purchasing.

A lot has been done in the field of IT, especially during the pandemic, when the whole world switched to online mode and majority of health-related services have been digitized. Now, all patient data is in electronic format and we do not use paper-based documents. All healthcare services are provided through Compulsory Health Insurance are recorded electronically. Also, external assessment of quality of care at health care organizations shifted to online form with electronic registries. It enables that at the end of each month, medical experts of the Insurance Fund electronically check healthcare quality.

Answer by **Gulzhan Shaikhybekova**, Director of the Department for the Coordination of Mandatory Social Health Insurance of the Ministry of Healthcare of the Republic of Kazakhstan:

In Kazakhstan, we did the following: 1) we abandoned the principle of budget utilization "by any means" according to budget procedures; 2) we introduced performance indicators when contracting for defined volumes of services with the health care providers; 3) the purchase and contract placement for health services was automated by 70%, monitoring the quality of medical services was automated (digitalized) by 50%, and payment procedures were automated by 90%.

The first point (avoiding budget utilization) has been resolved through changes in the treasury procedures. However, there are problems with the burden of administration of two packages of health services from two sources (a package of guaranteed free medical care and a package of insurance services for the insured).

In addition, the issue of decentralization of the budget of the Social Health Insurance Fund is currently being considered.

Answer by **Klara Oskombayeva,** First Deputy Chairman of the Mandatory Health Insurance Fund under the Ministry of Health of the Kyrgyz Republic:

About ten years ago we built contractual relations with health care organizations and determined the exact volume of services to purchase from them. However, we are still at that level. In the last two years, we have been intensively engaged in the improvement of IT systems, after which this will allow us to be better prepared in this matter.

Over the past 10 years, the basic package of medical services at the outpatient level under the State Guaranteed Program for the entire enrolled population for the purpose of UHC has expanded to priority diseases. Newly covered services include: determination of blood cholesterol, glycated hemoglobin in the blood for patients with diabetes, and urinalysis for bacteriuria

(women in the first trimester of pregnancy). The list of subsidized drugs at the outpatient level also has been expanded to metformin for patients with diabetes and the antihypertensive drug Bisoprolol for all patients with hypertension, regardless of insurance status.

Question 2 (Joseph Kutzin), for **Azerbaijan:**

Government budget funding of insurance, as described in Azerbaijan, is very consistent with global trends in terms of de-linking entitlement from employment status (if we think the "right" to coverage derives from being a person rather than from being a worker per se). It also sounds like the transfers (e.g. from TB program) are a means to reduce fragmentation that arises from vertical programs. Did you face resistance from these programs (e.g. TB, HIV, etc.) on the decision to channel some of their budgets into the Fund, rather than financing their services (and facilities) separately?

Answer by **Nigar Bayramova**, Deputy Chairman of the Executive Board of the State Agency on Mandatory Health Insurance of the Republic of Azerbaijan:

We encountered some resistance from the Ministry of Finance, who wanted to finance us only through insurance premiums for each citizen. So far, in the first years of implementation, we are keeping the programs with separate budgets (vertical programs) – for us, these are separate finances, that is, additional funding. Otherwise, if we include these programs in our insurance package, we will need to change the legislation, increase the insurance premium paid by the state – all of this is not guaranteed, so for the time being it is beneficial for the Insurance Fund to have separate budget allocations in this direction.

Question 3, (**Zhanar Bozzhigit),** for **Azerbaijan:**

Does health insurance include free medicines in your country?

Answer by **Nigar Bayramova**, Deputy Chairman of the Executive Board of the State Agency on Mandatory Health Insurance of the Republic of Azerbaijan:

So far, insurance-covered free medicines are provided only at the inpatient level in hospitals. At the outpatient level, that is, on the basis of a prescription, health insurance does not yet provide such a service. But we proposed a new package of services to the Government, in which, for a start, we have included some medicines that would be provided free of charge at the outpatient

level. As this package of services is approved, these services will become available and free medicines will be provided through compulsory health insurance.

Question 4, (Anar Toktabayanova), for **Azerbaijan:**

What does it mean that you merged small health care organizations with larger ones?

Answer by **Nigar Bayramova**, Deputy Chairman of the Executive Board of the State Agency on Mandatory Health Insurance of the Republic of Azerbaijan:

Our country is divided into regions, and some regions had both a central regional hospital and a diagnostic center. We combined them to make it easier to manage and finance them, as well as to ensure that the flow of the population passes through the district hospital. Earlier, it caused fragmentation and inefficiencies since each doctor of the diagnostic center had his own patients. The merger of small organizations took place and now the flow of citizens is to one district (rural) hospital and from there referred, if necessary. It facilitated their management and we gained economies of scale in running the accounting, personnel management and other functions.

Question 5, (Ariuntuya T) for **Azerbaijan:**

How extra revenues levied on tobacco/ alcohol/ gas are distributed within the health system in Azarbaijan?

Answer by **Nigar Bayramova**, Deputy Chairman of the Executive Board of the State Agency on Mandatory Health Insurance of the Republic of Azerbaijan:

In addition to contributions for compulsory health insurance, there are additional sources of revenue that makes up the funds for compulsory health insurance. These are additional revenues are collected from the sales of tobacco products, alcoholic and energy drinks, gasoline, diesel fuel and liquefied gas. These funds are fully directed to cover the compulsory health insurance expenditures. There is no targeted distribution of these funds within the healthcare system other than pooling with health insurance expenditures.

Question 6 (Joseph Kutzin) question for **Kazakhstan:**

Kazakhstan was one of the first CIS countries to introduce mandatory health insurance, back in 1996. But it was cancelled after 1998, and one reason for this was that different funding sources were not coordinated. Although revenues collected from employer-employee contributions

added about 0.5% of GDP to health revenues, oblast governments withdraw their former funding of health by about 1.5% of GDP, leading to a drop in gov't spending on health by about 1% of GDP. For this second wave of Health Insurance Reform, how is Kazakhstan coordinating these different revenue sources so that you don't get the same problem?

Answer by **Bolat Tokezhanov,** Ex-Chairman of the Board of "Social Health Insurance Fund" of Kazakhstan:

In 1996, at that time, there was a complete decentralization of budgetary resources in the budgeting system of Kazakhstan. In that period, health care was practically managed at the district (rural) level. Accordingly, each district mayor (rayon administration) transferred funds from the rayon budget to the Compulsory Medical Insurance Fund (FOMS).

And starting from 2005, as Maksut Karimovich Kulzhanov already noted in his speech, centralization took place at the regional level.

Since 2017, we have had a complete centralization of budget funds for a guaranteed volume of free medical care at the level of the Ministry of Healthcare.

Taking into account the concept of health insurance, it was decided that for the non-working population – for preferential (vulnerable) categories, this is about 11.5 million people (out of 19 million people in the country), which includes children, pensioners, pregnant women and other categories, according to the Law on Health insurance, contributions are made by the Ministry of Finance centrally. Accordingly, these funds are transferred from the Ministry of Finance to the accounts of the Ministry of Healthcare, and then the Ministry of Healthcare directs these funds to the Social Health Insurance Fund. Thus, based on the population numbers, the Fund distributes these resources.

Question 7 (Sherzodbek Inakov) question for **Kazakhstan:**

Are there any problems with waiting lists for patients to receive medical services under mandatory health insurance in Kazakhstan? How does the country deal with wait lists?

Answer by **Gulzhan Shaikhybekova**, Director of the Department for the Coordination of Mandatory Social Health Insurance of the Ministry of Healthcare of the Republic of Kazakhstan:

Yes, we had very big problems, and these problems with the waiting lists remain today. But what steps have we taken to reduce patient wait times for services?

Firstly, when monitoring and examining the quality of medical services, we introduced a "defect" (performance indicator) called "waiting for a consultative and diagnostic service for more than 10 days". So we've set the standard for outpatient organizations to deliver these services within ten days.

What mechanisms were used in Kazakhstan? We have increased the number of co-contractors (subcontractors); expanded the range of suppliers, including through the private sector. If in 2017 only 17% of health care providers working with the single payer were from the private sector, today half of the contracted health care providers are private entities. We have involved them to help reducing wait times. In addition, the participation of hospitals in the provision of outpatient services has been expanded. Hospitals were requested to participate as co-executors (subcontractors) of health service providers – I'm talking about the outpatient level here. Also, a large program is underway in the regions to ensure equipment and device supply mainly for expensive services – such as the MRI, CT and genetic tests. The availability of supplies and biomedical equipment has improved significantly, but the problem still remains. Today, several regions are in the high wait list zone for consumers – so this is issue is so far relevant.

Regarding inpatient services, we also have high waiting times there: about 38% of patients who are hospitalized on a planned basis (for elective care) are waiting for more than 30 days. What are we doing? We are expanding the volume of medical services in the most demanded types of care.

Question 8 (Joseph Kutzin) question for **Kyrgyzstan:**

Kyrgyzstan achieved so much through the single payer reform that showed how to make different funding sources explicitly complementary, relying mainly on general revenues given the nature of the economy, but providing a means to pay for outputs rather than inputs from these revenues. One constraint in the past was that the public financial management (PFM) rules in the country remained a bit rigid in terms of forming budgets by inputs and also a degree of input-based control on managers of government health facilities. Have the PFM rules and health financing reforms become more "mutually supportive" in recent years? This is a very important issue in health financing reform for countries around the world, so would be good to hear of Kyrgyzstan's progress in addressing this.

Answer by **Klara Oskombayeva,** First Deputy Chairman of the Mandatory Health Insurance Fund under the Ministry of Health of the Kyrgyz Republic:

The creation of the single payer system made it possible to accumulate funds from the republican budget and compulsory medical insurance at the Compulsory Medical Insurance Fund and to create a single channel for financing health service providers. At the same time, financing of suppliers is carried out on a non-item basis (not linked to strictly regulated budget-item codes). Health care providers now independently and freely allocate their internal budget according to their needs. However, reporting of health service providers on the use of financial resources is provided in the context of spending categories.

Question 9 (Joseph Kutzin), question for **Kyrgyzstan:**

Most economists believe that even if payroll contributions are not explicitly levied on employees, they are still transferred to employees in the form of lower wage growth. In Kyrgyzstan, the contribution for health is small, but it is one part of overall social contributions (e.g. pension, unemployment, etc.). Any evidence on how this may or may not have affected wage growth?

Answer by **Klara Oskombayeva,** First Deputy Chairman of the Mandatory Health Insurance Fund under the Ministry of Health of the Kyrgyz Republic:

Unfortunately, insurance premiums did not affect the growth of wages, since the volume of benefits provided does not depend on the volume of incoming insurance payments.