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Toward a More Pro-Poor and Explicit Health Benefit Package in the Kyrgyz Republic

A Critical Review of the Stated Guaranteed Benefit Package and Options for Its Revision

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Contents

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Abbreviations

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

Summary

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

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

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

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

I. Introduction

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

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

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

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

The current paper provides a critical review of the health benefit package in the Kyrgyz Republic and offers several directions for its revision. It represents a significant addition to the existing literature in several ways. First, it highlights the key bottlenecks limiting the SGBP's ability to serve as an instrument for achieving effective universal health coverage. It then offers practical recommendations to guide the revisions of the SGBP. The primary audience of this paper is key health sector stakeholders in the Kyrgyz Republic, in particular the Ministry of Health (MoH), MHIF, Ministry of Finance (MoF), and Ministry of Labor and Social Development (MoLSD). As the country determines to take systematic steps in revising the SGBP in the coming years, this paper will provide a useful framework to guide such efforts. In addition, by sharing the Kyrgyz experience, the paper contributes to the international literature, which so far mainly touches upon broad level principles of health benefit packages. As more and more countries are struggling to balance between ambitions and constraints in defining and revising their health benefit package, the lessons from the Kyrgyz Republic will be useful for them in developing their own practical solutions.

In the followings, section 2 sets the stage with a brief review of common approaches in defining health benefit packages. Section 3 starts with a description of the "statutory benefit package" in the Kyrgyz Republic – the SGBP as it is specified in the legal documents – and provides a critical assessment of its

actual performance. As a preview, challenges facing the "de facto" SGBP do not only rest in the funding shortage, although this certainly is a major issue. The de facto SGBP also falls short in the lack of clarity and transparency, in the overwhelming size of the population entitled to free services given the government's limited ability to fulfil such promise, lack of an effective poverty targeting mechanism, weak information base for monitoring and management, and most importantly, lack of a systematic methodology and mechanism for its revision. Recommendations to address some of the challenges are provided in Section 4 and Section 5 concludes.

II. Approaches in defining health benefit packages

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

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

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

With the heightened global attention to UHC, a general movement toward explicit benefit packages has been observed in many countries. Specifically, among 24 UHC programs recently reviewed by the World Bank, all but three adopted an explicit package and used complex mechanisms in setting priorities for these packages (Cotlear et al., 2015). For example, in Thailand, the benefit package is defined by positive and negative lists, consisting of health conditions, clinical procedures, and other detailed categories. In Estonia, the benefit package is defined by the so-called "List of Health Services" (based on government decision). It has an explicitly defined benefit package structured as an inclusion list. In Mexico, program Seguro Popular administers two explicit healthcare packages: a set of mainstream primary care and general hospitalization services that includes 284 interventions and a set of high-cost/high-complexity services that includes 61 interventions. The two explicit benefit packages were deemed effective tools for achieving UHC in the country (González-Pier, 2017). Across countries in Latin America and the Caribbean, adopting explicit benefit plans to cover the entire population or target groups has become a popular pattern (Giedion et al., 2013).

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

The benefit package discussions go way beyond "what's in, what's out." Intrinsically related to the package of services are issues such as cost-sharing process, how benefits are administered, incentive and care delivery options, complaint review process, among others. For the example, some of the key features of a health benefit package recommended by the Institute of Medicine to health plans participating in the "Obama Care" in the United States are listed below (Box 1).

Box 1. Benefit package design includes

1. A description of the covered benefits: services, drugs, devices
2. A description of the cost sharing process
3. A list of coverage exclusions
4. Identification of provider networks, incentives, and care delivery options
5. Medical management and/or utilization management programs (e.g., when prior authorization is required for specific services; site of service, level of care, or preferred providers)
6. Payment policies that affect coverage or cost-sharing
7. Overall description of how benefits are administered, including description of the complaint, request for review, and appeals processes
8. …

Source: reproduced with simplification from the Institute of Medicine (2012).

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

III. The State Guaranteed Benefit Package in the Kyrgyz Republic

1. Regulatory framework and institutional arrangement for the SGBP

The SGBP is administered through the program of the state guarantees to ensure a volume, types and conditions of provision of medical care to the people, ensuring the realization of their rights to health care in accordance with Kyrgyz legislations. According to the Health Care Law, the MoH is responsible for the development of the SGBP while the MHIF is responsible for its administration. However, decisions regarding the SGBP go way beyond the health sector stakeholders.

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

- The MoH: is responsible for defining and revising the SGBP, often in collaboration with the MHIF;
- The MHIF: takes part in the development of SGBP and acts as a Single Purchaser of the SGBP. In case of the financial shortfalls, MHIF can initiate proposals on the revision of SGBP;
- The MoLSD: is tasked with developing policies and administering various social support programs that have direct implications on the beneficiary population of the SGBP. Specifically, it administers the categories of the population who are eligible for free or subsidized services based on their social status (social categories). At present, there are 30 such categories. The MoLSD is also in

charge of identifying and certifying the poor, some of them are included among the 30 "social categories" of the SGBP;

- The Government: approves the SGBP proposed by the MoH;
- The MoF: examines and approves the state budget proposals for health, with SGBP comprising nearly 80% of the total;
- The Parliament: approves financial parameters for the respective year for the SGBP.

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

As can be seen, the process of revising the SGBP involved many steps and multiple stakeholders, which typically lead to a delay in the approval of the package. For example, in 2015 the SGBP was not approved until November. Due to the challenges in the annual revision of the SGBP, after 2015, it was decided that the SGBP would only be revised "when needed" and there has been no major revision since then.

2. The statutory benefit package

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

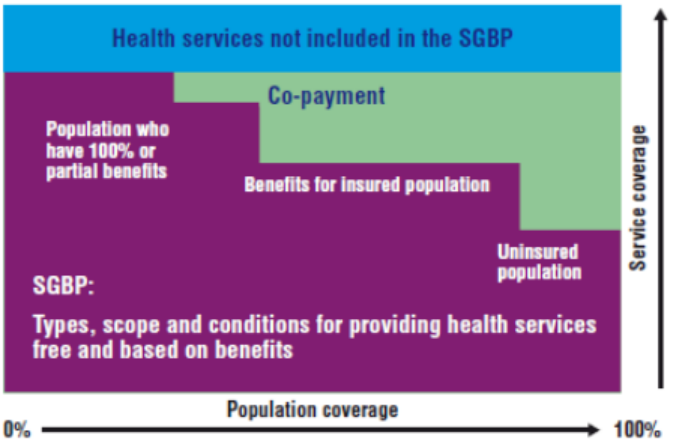
As per the Law, the state guarantees program provides the following types of medical services:

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

A pictorial presentation of the SGBP is below (figure 1). As shown, basic services, which include health promotion, prevention and some basic lab tests at the PHC level, are made available for free to 100% of the population regardless of insurance status. For people having social health insurance, coverage is higher and co-payment for non-free services is lower. Certain population groups enjoy 100% or partial benefits, which are usually higher than the benefits for insured people (the so-called "population who have 100% or partial benefits" in the diagram). Currently, there are 30 groups for whom benefits are granted based

on their social status and 16 groups for whom benefits are granted based on their underlying medical conditions. The architecture of the SGBP remains unchanged since its inception.

Figure 1. A pictorial presentation of the SGBP



Source: Reproduced from Kutzin et al. (2002)

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

Table 1. MHIF's funding for purchasing the SGBP, 2018

Funding for purchasing the SGBP by level of care	**'000 Kyrgyz Soms**	**%**
SGBP at PHC level	4,619,023	32.5
PHC services	*3,852,337*	*27.1*
Ambulance services	*447,250*	*3.1*
Drug benefits under State program	*55,000*	*0.4*
Additional Drugs Package	*264,435*	*1.9*
SGBP at Hospital level	9,181,303	64.5
General inpatient services	*8,644,698*	*60.7*
Specialized services (oncology, psychology, hematology, cardio-surgery)	*536,605*	*3.8*
Hemodialysis	286,000	2.0
Administration	144,000	1.0
Total	**14,230,326**	**100.0**

Source of data: MHIF, 2018
Note: exchange rate 1 US$=70 Kyrgyz Soms

Details of the SGBP are provided below:

(i) Primary health care

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

Basic laboratory tests in PHC included in SGBP are:

- complete blood count;
- urinalysis and the microscopic sediment examination;
- urethral smear microscopic examination;
- vaginal swab microscopic examination;
- sputum microscopic examination;
- blood glucose;
- urinary glucose;
- blood cholesterol

(ii) Inpatient care

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

(iii) Dental care

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

(iv) Outpatient drug benefits

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

The list of drugs that are allowed to be prescribed and sold within the two programs is included in the special "Directory of drugs reimbursed under the Additional Mandatory Health Insurance Program and the Program of the state guarantees," which is available in every doctor's office and pharmacy. The Directory of drugs contains more than 200 names of medicines and the reimbursement amount in Kyrgyz soms per one unit of dosage forms (a pill, a coated pill, an ampoule for injection, an extended-release pill, and a dose of aerosol, etc.).

Table 2. Beneficiary groups for outpatient drugs under the ADP and the Program of state guarantees

ADP program	The program of state guarantees
▪ Workers for whom the employer makes contributions to the Social Insurance Fund, ▪ Pensioners, ▪ Persons receiving social benefits, ▪ Children under 16, ▪ Farmers and their family members who pay insurance contributions to the Social Fund ▪ Persons with Medical Health Insurance policy	▪ Patients with epilepsy, ▪ Patients with bronchial asthma, ▪ Patients with paranoid schizophrenia, ▪ Patients with affective disorders, ▪ Cancer patients assigned to family group practice and subject to regular medical check-up

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

Under the Program of state guarantees, outpatient drug benefit includes a free of charge drugs list and a subsidized drugs list. Patients with insulin-dependent diabetes mellitus, non-insulin-dependent diabetes mellitus, diabetes insipidus, hemophilia and tuberculosis are entitled to free prescriptions. Patients with epilepsy, bronchial asthma, and cancer patients in the terminal stage are entitled to subsidized prescriptions. Both the list of conditions and volume allowed for each condition is very limited. For example, table below shows the list of conditions with free prescriptions.

Table 3. Diseases entitled to free prescriptions and respective volume caps

Disease	Drug or medical device	Rate of distribution per patient per year
Insulin-dependent diabetes	Insulin, syringes	As needed
Non-insulin dependent diabetes	Glibenclamide 5 mg	5 packages (600 pills)
Diabetes insipidus	Desmopressin 5 ml	20 vials
Hemophilia	Cryoprecipitate 15 mg	20 vials
Tuberculosis	Under DOTS Program	As needed
Children under 16 with hemophilia	Concentrates of factors VIII/ IX	6500 ME

Source: Government of the Kyrgyz Republic (2015)

(v) Copayment

Most of the primary care and outpatient specialist services are free. Some with copayment depending on the patients' status. For inpatient care, there is a rather simple co-payment scheme, defined at three levels (minimum, average, and maximum), separately for therapeutic and surgical profile and for tertiary versus other types of hospitals.

Table 4: copayment rates per hospitalization (Kyrgyz soms)

Forms of co-payment		All hospital excepts tertiary	Republican hospitals (tertiary)
Co-payment of the therapeutic profile	Minimum	330	330
	Average	840	1160
	Maximum	2650	2980
Co-payment of the surgical profile	Minimum	430	430
	Average	1,090	1,510
	Maximum	3,440	3,870

Source: Government of the Kyrgyz Republic (2015)
Exchange rate: US$1 = Kyrgyz soms 70

What co-payment level the patient is subject to depends on his or her insurance status and whether s/he belongs to one of the groups eligible for reduction or exemption. Citizens entitled to SGBP copayment reduction or exemption are divided in two categories:

- Citizens entitled to copayment exemption or reduction based on their social status (30 categories); and
- Citizens entitled to copayment exemption or reduction based on the clinical indications of the underlying disease (16 categories).

The list of social and medical categories is provided in Annex 1. As can be seen, the list is extensive. Many of the social categories can be considered people of merits (i.e., having served the country), while others can be considered disadvantaged (i.e., people with disability). However, it is not clear if all categories are in the financial need for full subsidization. The same observation is applied to the 16 medical groups. As reported by the MHIF, the benefits of most of the 30+16 categories are dictated by different laws and changes to their benefits would involve amendment not only in the SGBP regulations but also other respective laws as well.

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

There is a cap to inpatient benefits for most patients. For example, except for children under six, all social categories have a cap of two free admissions per year, and the third and higher admission of the year are subject to average copayment. Furthermore, there is no stop-loss provision in the SGBP.[1] On the opposite, the legislation stipulated that when the actual cost of providing medication to a patient is three times

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

higher than the average cost of the treatment, approved by the authorized state body in the field of mandatory health insurance, the treatment-and-control committee of the hospital may decide to charge additional costs for drugs required for further treatment at the expense of the patient, regardless of his/her entitlement to benefits.

(vi) Specialized services

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

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

- with the minimum level of co-payment to: pensioners and veterans of labor older than 70 years, persons with disabilities from childhood, persons receiving state benefits;
- with the average level of co-payment to: citizens insured by the MHIF, persons employed in agriculture who are paying contributions for compulsory health insurance, contracted military service persons with MHIF policy;
- with the maximum level of co-payment to: other categories of citizens.

Chemotherapy is provided with additional co-payment for all citizens based on the cost of services according to the MHIF price list.

There are restrictions expressed in a negative list. Citizens regardless of the entitlement to benefits shall pay according to the price list the cost of the following expensive examinations and manipulations:

- Angiography of peripheral vessels, brain vessel and internal organs;
- Angiocardiography for heart valvular defects;
- Hemosorbtion;
- Hemodialysis;
- Computer tomography;
- Coronarography;
- Plasmapheresis;
- MR-imaging;
- Lithotripsy.

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

From the description above, it is clear that the SGBP at a close look is more complicated than its pictorial representation shown in figure 1. Table 5 attempts to put together the main contents of the SGBP by level of care and population groups.

Table 5. The main content of the SGBP by level of care, population groups, and fee (copayment) level

Services/Patient category		30 social conditions	16 medical conditions	Insured	Rest of the population
Primary Health Care	*Prevention, basic lab*, therapy*	Free	free	free	free
	Other labs	Free	free	free	full price
	Rehab, physiotherapy	full price	full price	free	full price
Outpatient care (OP) except specialized services	*2ndary care OP setting*	Free	free	full price	full price
	Advisory & diagnostic department hospital	Free	free	full price	full price
Inpatient care (IP) except specialized services		free for 2 IPs/yr, average copay from 3rd (except U5 and some categories)	free, no limit	average copay	max copay
Outpatient drugs	*General*	discount for some beneficiaries categories	discount if among specified diseases	discount	full price
	Specific diseases	free or discount depending on diseases			
Inpatient drugs		free up to 3 times average cost			
Specialized psychiatric care	*Outpatient*	free	free	free	free
	Inpatient	free	free	free	free
Oncological care	*Outpatient*	free for some beneficiaries categories	free for some beneficiaries categories	free	full price
	Inpatient	free for some beneficiaries categories, some categories have max copay	free for some beneficiaries categories, some categories have max copay	average copay	max copay
Hematological care	*Outpatient*	free	Free	free	free
	Inpatient	free for some beneficiaries categories, some categories have max copay	free for some beneficiaries categories, some categories have max copay	average copay	max copay
Cardiac surgery and organ transplantation	*Outpatient*	free for some beneficiaries categories, some categories pay full price	free for some beneficiaries categories, some categories pay full price	full price	full price

	Inpatient	free for some beneficiaries categories, some categories have copay based on the specific formula	copay based on the specific formula	copay based on the specific formula	copay based on the specific formula

Source: authors, based on the SGBP description (Government of the Kyrgyz Republic, 2015)

3. A critical assessment of the SGBP

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

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

(i) Complicated and confusing

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

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

Table 6. Population knowledge about the SGBP at PHC

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

Type of the services	Free (%)	Not free (%)	Do not know (%)
Consultation with primary care practitioner	93.7	2.9	3.4
Consultation with specialist	60.3	27.2	12.5
Blood or urine test	51.6	43.4	5.0
Hormone analysis, kidney test, test for rheumatism	12.9	65.1	22.0
Blood pressure measurement	87.5	5.9	6.6
Ambulance services (except private)	70.2	16.1	13.7
Ultrasound for pregnant women	33.1	42.5	24.4

Source of data: KIHS 2014

The first point to note from the table is that there was a large percentage of people giving a wrong answer. For example, the percentage of respondents who thought fees would be required for services that are free by the SGBP regulation was 43.4% for basic blood and urine tests, 16% for ambulance service, and 42.5% for ultrasound for pregnant women. But this could be due to the fact that people do have to pay extra for free services rather than poor understanding of the SGBP. More remarkable is that an appreciable proportion of respondents actually did not know if common services at PHC were free (13.7% for ambulance services and 24.4% for ultrasound for pregnant women). Given that PHC should be the most frequent provider, the low awareness of the SGBP at PHC is concerning and this could partly explain why PHC is not attractive to the population.

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

Table 7: Population knowledge about outpatient drug and inpatients benefits under the SGBP

Questions	Yes	No	Do not know	Not applicable
Are you entitled to receive outpatient drugs at subsidized prices?	46.0	42.2	11.8	
Are your children under 16 years of age entitled to receive outpatient drugs at reduced prices?	28.4	33.2	22.7	15.8
Imagine that you have been hospitalized. You have already paid an official co-payment. Do you have to pay in addition to medical personnel?	14.1	74.8	11.1	
Imagine that you have been hospitalized. You have already paid an official co-payment. Do you have to pay in addition for medicines during your hospitalization?	36.6	51.4	12.0	

Source of data: KIHS 2014

(ii) Not explicit and hence not transparent and guaranteed

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

the sub-section above. The situation creates a murky area as whether certain therapeutic services, procedures, tests, and supplies are subject to MHIF reimbursement.

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

(iii) Limited coverage even for included services

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

For example, in 2017, spending on the ADP accounted for less than 1.8% of MHIF spending and only 900,000 prescriptions were reimbursed. Given that there were about 4.5 million insured people, this translates to 0.2 prescription per person per year. The normative used by the MHIF is US$ 1 per insured patient. Furthermore, due to the lack of a mechanism to control price and regulate mark-up, effectively, reimbursement from the MHIF is often less than 50% of the retail price. Anecdotal evidence reveals that the retail price of some basic drugs in the Kyrgyz Republic is higher than in higher income countries, yet imposing another layer of financial burden on the patients.

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

As revealed in table 8, in 2017 MHIF reimbursed on average 1.7 prescriptions per registered hypertensive patient. While it is not clear from the database how long one prescription lasts for, the amount is just a little over US$4 equivalent. For diabetes and anemia, the two common and high burden conditions in the country, coverage is much less. And for contraceptives, less than 6,000 prescriptions were reimbursed in 2017 compared to over 1.5 million women of reproductive age. Even though not all women of reproductive age would need contraceptives, the amount spent by MHIF was just low by any standard.

Table 8. MHIF's reimbursement under the ADP compared to estimated need

Conditions	Reimbursed prescriptions	Amount (US$ equivalent)	Estimated population in need	Prescription per person in need	Amount per person in need (US$ equivalent)
Hypertension	284,434	705,153	169,412	1.68	4.16
Diabetes mellitus	1,140	13,328	56448	0.02	0.24
Anemia	131,323	568,575	812,800	0.16	0.70
Contraceptives (injection and oral)	5,959	50,279	1,569,594	0.00	0.03

Source of data: (1) for MHIF's reimbursement: ADP database; (2) For population in need: number of people with hypertension and diabetes represents the registered cases recorded by eHealth center; number of people with anemia is a sum of estimated number of children ages 0-5 with anemia and estimated number of women ages 15-49 with anemia (source: WDI); people in need of oral and injection contraceptives are women ages 15-49. All data are for 2017 except the estimated population in need for anemia drugs and contraceptives (2016). Exchange rate: US$1=Kyrgyz soms 70.

The inclusion of specialized services (psychiatry, oncology, hematology, and cardiac surgery) under the Single Purchaser system in 2016 was not accompanied with adequate funding. For example, in 2016, there were roughly 4,200 surgeries, 1,500 patients on chemotherapy, and 600 patients on radiotherapy at the National Center for Oncology and Hematology - the only facility providing complete cancer treatment. While there is no accurate data on the number of cancer patients in the country, there are approximately 11,000 new cancer patients in the Kyrgyz Republic per year, far more than the number receiving treatment[2]. Similarly, according to the description of the SGBP, heart surgery for children under one year of age should be 100% covered by MHIF. However, in reality only 10%-15% is covered.

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

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

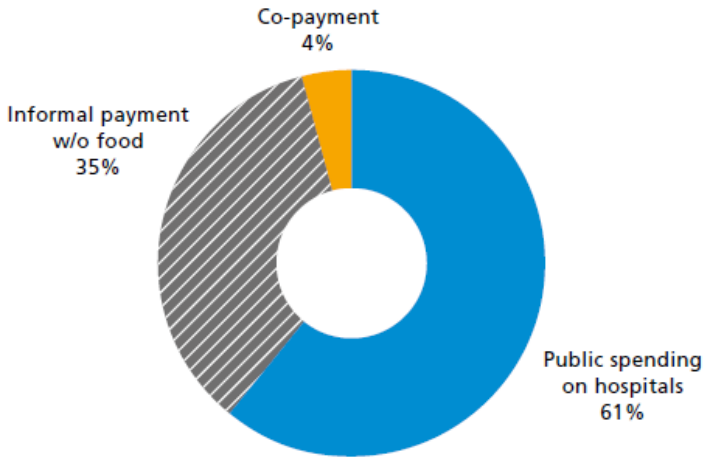
Table 9. MHIF payment and median cost of certain inpatient services, 2018 (Kyrgyz soms)

Diagnosis and procedure	MHIF payment	Median cost
Acute upper respiratory infection, unspecified	4,745	9,271
Hepatitis A without hepatic coma	11,351	11,198
Type 2 diabetes mellitus with multiple complications	9,208	12,154
Pneumonia, unspecified	6,309	11,915
Classical cesarean section	7,515	8,049
Appendectomy	5,382	9,419
Cholecystectomy	6,510	9,440
Laparoscopic cholecystectomy	6,070	14,829

Source of data: The World Bank (2019b, forthcoming) preliminary results

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

Figure 2: Source of inpatient financing



Source: Jacab, Akkazieva, and Kutzin (2016)

(iv) Generous exemption policy but no effective protection of the poor and against catastrophic payment

The extensiveness of the list of population eligible for copayment reduction or exemption has been documented in several previous studies (Giuffrida, Jacab, and Dale, 2013; The World Bank, 2014). Indeed, as shown in table 10 below, out of 933,623 total treated cases reported to the MHIF in 2017, nearly 432 thousand cases belonged to the social categories that enjoyed 100% benefits. In all, MHIF had to pay the hospitals on behalf of patients in the social and medical categories in 74% of the time. This is also

equivalent to 75% of total spending on treated cases (figure not shown). As one can also inferred from the table, 22% of the full benefit categories are uninsured (137,970 out of 627,863). The uninsured group largely falls under the medical categories because most of people in the social group have insurance premium covered from the government budget already. Specifically, 66% of the treated cases receiving full benefits belong to the uninsured group. The coverage of social health insurance coverage in the Kyrgyz Republic is reported to be between 65%-75%, and the policy to provide generous benefits to uninsured people based on a large number of medical conditions will not be helpful in boosting further the coverage.

Table 10. Number and share of the beneficiary groups in the total number of treated cases (2017)

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

Source of data: MHIF
Note: the total number of treated cases do not include foreigners

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

- The SGBP does not contain an explicit poverty targeting mechanism. Although many of the 30 social groups generally can be considered disadvantaged, the only category that is related to poverty is "Children under 16 years old from low-income families with four or more children." Thus, other people in low income families are not eligible, unless they are included in the other groups. Furthermore, the method to identify and certify low-income families employed by the MoLSD has been notoriously reported to be problematic. The SGBP has been documented to suffer from both significant inclusion and exclusion errors as far as poverty targeting is concerned. A study conducted by WHO using 2010 KIHS data revealed that an estimated 57% of the eligible were not poor while an estimated 51% of the poor were not eligible for SGBP benefits (Jamal and Jacab, 2013).
- The SGBP does not have a cap on the maximum amount of out-of-pocket payments patients are responsible for within a certain period of time (such as one year). The cap, which is typically known as a "stop-loss provision" is an arrangement that allows patients to stop paying out-of-pocket once their total payments have reached a specific limit, and it serves to protect patients from

catastrophic expenditures. This mechanism helps lessening the impoverishing impact of medical care and it exists in most developed health systems (Paris et al., 2016).

(v) Weak information base for monitoring and management

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

Fragmentation and lack of sharing

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

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

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

Inadequacy of data

One important subgroup of inpatients comprises those that are called 'non-acute' or 'chronic' inpatients in some countries. There is no separation between 'acute' and 'non-acute' care in Kyrgyz Republic and due to this there is a shortage of information for health sector planning. If this kind of care is not recognized, it cannot be counted. The absence of good information means that it is difficult to ascertain whether more non-acute inpatient care should be provided, or whether (say) more home nursing should be made available so that patients no longer have to remain in hospital.

Another problem is that there are not any data on procedures performed at the PHC level. Such PHC procedure classification classifies patient data and clinical activities in the domains of General/Family Practice and primary care, taking into account the frequency distribution of problems seen in these domains. It allows for classification of the patient’s reason for encounter, the problems/diagnosis managed, interventions, and the ordering of these data in an episode of care structure. Without a classification system, it is impossible for the MHIF to monitor what procedures are being delivered to the population at the PHC level.

Low quality of data

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

Table 11. Structure of morbidity in adults and adolescents, 2016

Diseases	Number	%
TOTAL	**2.093.755**	**100**
Diseases of the circulatory system	298.290	14,2
Diseases of the digestive system	282.020	13,5
Diseases of the respiratory system	274.706	13,1
Diseases of the genitourinary system	235.402	11,2
Diseases of the nervous system	126.518	6
Diseases of the eye and its appendages	121.278	5,8
Diseases of the endocrine system	116.179	5,5
Diseases of the blood	88.308	4,2
Diseases of the musculoskeletal system	87.077	4,2
Injuries and poisonings	86.467	4,1
Diseases of the skin and subcutaneous tissue	77.593	3,7
Diseases of the ear and mastoid process	73.818	3,5
Pregnancy, childbirth, and the puerperium	72.115	3,4
Mental disorders	61.676	2,9
Some infectious and parasitic diseases	56.524	2,7
Neoplasms	29.826	1,4
Congenital anomalies	3.686	0,2
Symptoms, signs and inaccurately marked	2.272	0,1

Source of data: ReHC

As it can be seen, Diseases of the circulatory system are responsible for 14.2% of the total morbidity in adults and adolescents. On the other hand, according to the Global Health Observatory data, approximately 22% of the population of the world have hypertension. This means that reporting system in Kyrgyz Republic is likely not accurate, or there are many undiagnosed patients, or both. A similar case applies to endocrine system diseases (which include diabetes). According to the STEP survey (WHO, 2013), the estimated prevalence of diabetes among adults in the Kyrgyz Republic is around 6%. Yet only 116,179 cases are registered with endocrine system diseases for a total population of six million.

(vi) Lack of clear procedures and institutional arrangements for revision

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

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

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

IV. Toward a more pro-poor and explicit benefit package

From the section above, it can be seen that a number of measures are needed to improve the effectiveness of the SGBP in fulfilling its mission of ensuring the right to health care for all citizens in the Kyrgyz Republic. A non-exhaustive list of needed actions could be:

- To simplify the SGBP and conduct campaigns to raise population awareness of their entitlements, and to improve transparency and accountability of the providers;
- To move gradually toward a more explicit version of the SGBP, in line with international trend and best practices;
- To refine the exemption groups and make it more explicitly poverty targeted, also in line with international trend and best practices;
- To implement a whole array of measures to improve efficiency, reduce cost, and control price among providers and pharmacies; and
- To improve the data system and generate more data for decision making, including costing data.

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

Increasing copayment is also not a recommendation. Without putting in place a well-functioning poverty targeting mechanism, increasing copayment may make it more harmful for the poor and may exacerbate the differential benefits given to the non-poor population. More research will need to be done to understand the effects of copayment increase vis-à-vis the potential to raise additional revenue and distributional impact on different population groups.

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

1. Making poverty targeting central in the subsidization of the SGBP

As shown above, two conflicting issues prevail in the list of population eligible for copayment exemption or reduction: (1) the list is too broad and generous given the resource constraints; and (2) on the other hand, the list does not provide adequate protection to the poor from the financial hardship of health care.

It is noteworthy, however, that the situation is not unique for the Kyrgyz Republic. The review of 24 universal health coverage programs conducted by the World Bank reveals that most programs have multiple target populations; most programs aim for the poor, but very few if at all are only for the poor - “vulnerable” groups often include also mothers, children, the elderly, people with specific diseases, and

people with special historical categories and hot political targets (Cotlear et al., 2015). Within the countries from the former socialist block in the Eastern Europe, it is rather common to find veterans from World War II or victims of Chernobyl among the exemption group, as well as pensioners. At the same time, across the programs reviewed by the Bank, there is an increasing recognition of the risk of medical impoverishment and efforts to improve the targeting of benefits for the poor (Cotlear et al., 2015).

For the SGBP in the Kyrgyz Republic, the discussions were often around the possibility of shortening the list of categories eligible for subsidized care. Such proposal to remove certain eligible groups has proved to be politically challenging, even though the reality of budget constraint is well perceived as well as the need to better protect the poor.

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

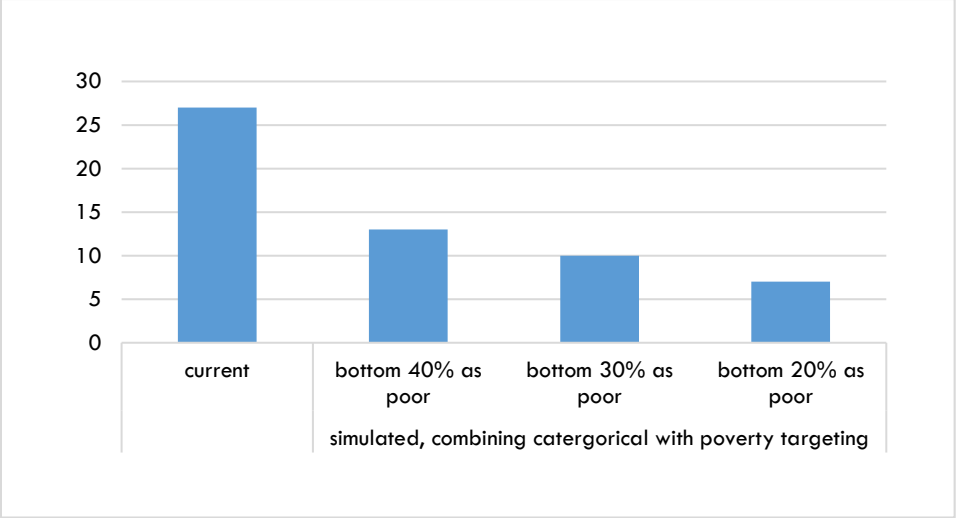
Box 2. Romania: categories of insured persons who are exempted from co-payments in inpatient treatment

- Children up to 18 years old; youngsters aged between 18 and 26 who are high-school students, high-school graduates for up to three months after graduation, students or apprentices, **provided they do not have income from work;**
- Sick people covered by the national programs of the Ministry of Health, for the medical services related to their main disease, **provided they are deprived of income of any source;**
- Pensioners **whose income does not exceed RON740 (€163) per month**;
- Pregnant women and women who have just given birth, for medical services related to pregnancy **and those who have no income or have incomes below the minimum gross wage** for all medical services.

Source: MISSOC, the 'Mutual Information System on Social Protection' (2016)

To illustrate the idea, a simulation was performed using 2014 KIHS data. In the figure below, the first bar represents the whole eligible population as currently defined based on the 30+16 categories. Note that this is a hypothetical figure because the survey does not allow for a full identification of all categories. Using consumption expenditure, three “poor” groups were estimated based on different criteria: bottom 40% of the population, bottom 30% and bottom 20% (the poorest quintile). If one combines the current eligible criteria (30+16) with poverty status, the size of the group eligible for SGBP copayment exemption or reduction reduces as shown in bars 2, 3, and 4 in the figure.

Figure 3: Hypothetical scenarios of SGBP exemption eligible population size with poverty filtering



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

The above is a hypothetical example and much more work needs to be done to derive a precise estimate, with consideration of each and every current category. However, it provides a practical option to operate within the budget constraint and navigate the political pressure associated with the exemption groups.

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

2. Building on the existing extensive clinical guidelines and care pathways to develop a detailed list of services included in the SGBP

The Kyrgyz Republic has a very large number of clinical guidelines and care pathways developed early on.[3] Since 2002, around 380 clinical guidelines and 200 care pathways were developed**.** Clinical guidelines and care pathways are divided in groups based on the specialty, including but are not limited to obstetrics and gynecology, allergology, gastroenterology, hematology, dermatology, etc. The majority of the guidelines provided guidance on maternal and child health (29.2%) and followed by infectious and parasitic diseases (27.7%). All guidelines are based on international evidence. For example, for the development of the guideline for Uncomplicated pregnancy, Multiple pregnancy, Acute pyelonephritis in pregnancy, Spontaneous miscarriage, Premature labor, and Infections during pregnancy, the following international sources/journals were used:

[3] Clinical guidelines: documentation that advises on the clinical management (including screening, preventative, diagnosis, treatment, prevention, rehabilitation and palliation) of individuals in a particular setting for a particular disease area/condition; Care pathway: multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimized and sequenced either by hour, day (acute care) or visit (homecare).

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

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

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

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

(i) Uncomplicated pregnancy

A collection of clinical protocols for Uncomplicated pregnancy; Multiple pregnancy; Acute pyelonephritis in pregnancy; Spontaneous miscarriage; Premature labor; Infections during pregnancy was published by the MoH in 2013. This guideline lists every health intervention that the current national policy dictates should be provided under antenatal care for uncomplicated pregnancy. It includes 6 antenatal visits. Table 10 below presents an example of how data for antenatal visits can be separated into six categories: Name of the program (condition); Care provider; Procedures; Laboratory tests; Prescribed drugs; and Coverage. This provides a framework for a systematic approach to the creation of a standard set of health service benefits that are provided efficiently and effectively.

Table 12. Translating the guideline for uncomplicated pregnancy to an explicit list of services

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

FMC: family medicine center; TBD = To Be Determined

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

Table 13. Translating the guideline for uncomplicated pregnancy to an explicit list of services, a simplified version

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

(ii) Procedures on femur in emergency medical service

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

Table 14. DRG code and procedures for femur

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

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

Table 15. Translating the DRG for femur to an explicit list of procedures

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

(iii) Outpatient drugs

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

Table 16. Current coverage of concentrates of factors VIII/IX for children with hemophilia

Disease	Drug or medical device	Rate of distribution per patient per year
Children under 16 with hemophilia	Concentrates of factors VIII/ IX	6500 I.U.

As currently regulated, the total quantity per year is 6500 I.U. for each child regardless of hemophilia severity. However, the need for concentrates of factors is different depending on the level of severity, which is based on percentage of normal factor activity in blood. Therefore, outpatient drug benefit may be refined in order to differentiate concentrates of factors VIII/ IX availability based on severity of hemophilia (mild, moderate, severe). Similar solution can be applied to other diseases (drugs) included in outpatient drug benefits.

As it can be seen from the above three examples, the proposed strategy for revising the SGBP is built on the available resources and knowledge as much as possible. Furthermore, this principle will not only make the SGBP more explicit and precise, it will also help enforcing adherence to guidelines and referral

pathways, as well as facilitating further development of the guidelines themselves. Eventually this process will inform the areas subject to Health Technology Assessment (HTA) and help building capacity in this aspect as well.

3. Developing an approach to on-going regular revisions of SGBP

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

- To lead the process of SGBP revision, coordinating among different stakeholders;
- To lead and coordinate the systematic development of clinical guidelines and care pathways;
- To review new and high priority technologies (that have been selected through a transparent topic selection process) with consideration of their costs, benefits, equity and social impact, compared to current technologies and/or current practice using the best available evidence.

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

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

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

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

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

In summary, a roadmap for SGBP reform would include:

- Development of a legal framework which will define SGBP related decision-making process and institutional structures responsible for the revisions of SGBP;

- Creation of the SGBP Unit within the MoH, with full time staff and plan for staff capacity building in the related areas of the SGBP;
- Development of a detailed implementation plan.

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

V. Conclusion

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

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

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Annex 1. Categories of population eligible for copayment reduction and exemption

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

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

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

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

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

Annex 2: Key principles for defining and revising the health benefit package

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

Impacts on Individual Wellbeing

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

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

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

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

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

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

Population Health Gains

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

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

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

Equity

How well does this intervention align with equity objectives?

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

If so, in what ways?

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

If so, in what ways?

Respect for Clinician Judgment

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

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

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

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

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

Evidence-informed decision-making and evidence generation

- What evidence exists to inform assessment for each of these considerations? How robust is that evidence? Can reliable conclusions be drawn from the current sources of information?
- Where there are gaps, what kinds of evidence should be pursued to inform the assessment?
- Which, if any, indicators should be collected routinely in order to inform ongoing coverage decisions?

Fair Processes and Procedures

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

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

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

Once proposals are prepared, a next step is to establish a mechanism that will allow for discussion and deliberation around evidence and proposals as an input to making a recommendation for inclusion or exclusion. While deliberation is more commonly applied as part of Health Technology Assessment[4] (HTA), there are good reasons to consider including a process of deliberation around the entire portfolio of SGBP services and its subsequent adjustment as well. In many settings, deliberation ends with a recommendation to policy makers on the individual services or portfolio of services that are to be included in the SGBP, but fails to connect the recommendation with decision-making. In an ideal process, there is an obligation to consider the appraisal and its recommendations in decision making on whether services are included or excluded for public subsidy.

Decision-making process should include:

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

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

Annex 3. Examples of cap on put-of-pocket payment, OECD countries

Country	Annual cap for cost sharing
Australia	"Extended Medicare Safety Net": cap on out-of-pocket costs for outpatient services covered by Medicare (i.e. services provided by GPs, specialists, private clinics and private emergency departments). Beyond an expenditure threshold (which is indexed annually), Medicare pays 80% of the out-of-pocket costs. People on low incomes qualify for the Safety Net at a lower threshold. The pharmaceutical safety-net threshold for general patients is currently AUD 1,390.60 (USD 950) for the calendar year, while the concessional-patient threshold is AUD 345.00(USD 242). After reaching the threshold, general patients usually pay AUD 5.90 (USD 3.93) for each prescription for the remainder of the calendar year, while concessional patients receive prescriptions free of charge.
Austria	Maximum threshold of 2% of the annual income.
Belgium	Annual cap on cost sharing.
Chile	Annual cap on cost-sharing, plus a cap of 30% of annual household income for conditions or treatments in the GES program.
Czech Republic	Annual cap on all cost sharing.
Denmark	Annual cap of DKK 3,710 ($472 for pharmaceuticals. Other services of medical diagnostic and curative care are virtually free of charge.
Finland	Annual copayment cap of €636 ($677) in 2012 on cost sharing for health services provided by municipalities.
Germany	Copayments are capped at 2% of gross household income, reduced to 1% for the chronically ill.
Hungary	Entitlement to free pharmaceuticals for those whose medical expense exceeds 10% of the minimum pension (for households with income per capita < minimum pension = €100 in 2010).
Iceland	Cap on cost sharing for outpatient primary care, outpatient specialist contacts, clinical laboratory tests and diagnostic imaging.
Ireland	Annual cap on inpatient care, primary care and pharmaceuticals.
Israel	Annual cap on inpatient and outpatient primary care.
Japan	Monthly co-payment cap depending on age and income.
Korea	Expense limit for all cost-sharing is based on the average health insurance fee per year.
Luxembourg	Annual cap on all cost-sharing is based on the average health insurance fee per year.
New Zealand	Annual cap for pharmaceuticals; after a family has paid for 20 items, all medicines are free of charge for patients. In addition, co-payments are paid by patients enrolled at GP practice offering the VLCA scheme are capped (to NZD 17(USD 11.49) for an adult).
Norway	Annual cap for the combination of expenses on pharmaceuticals, consultations with physician in the primary health care sector, psychologists and psychiatrists, outpatient services in hospitals, laboratory tests, x-rays set at NOK 2040 ($344) in 2013.
Portugal	Annual cap on copayments for low-income elderly people for dental prosthesis and eyeglasses.
Sweden	Annual cap for all cost-sharing requirements. Annual cap on copayments for pharmaceuticals, set at SEK 1,800 (USD 203).

Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates; Baji et al. 2011 (reproduced from Paris 2016)